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ABSTRACT

Ten studies concerned with developing culturally sensitive programs for mental health treatment of American minority groups are presented. Chapters 1-5 discuss variables to be considered when creating such programs. Work in cross-cultural settings has raised questions about the validity of some of the newly developed psychiatric diagnostic criteria, as represented in the Diagnostic Statistical Manual III, when applied to culturally distinctive groups. Research is presented to demonstrate major variations in symptom presentations and "illness discourses," challenging the assumption that specific symptoms will be uniformly associated with diagnostic entities across cultures. Specific cultural variations and treatment needs are discussed for American Indians, Blacks and Mexican Americans. Chapters 6-10 represent the work of mental health clinicians and administrators who draw from their experience treating Hispanics. Asians, Pacific Asians, and people from Cuba, Haiti, Puerto Rico, and the Bahamas. Emphasis is on delivery of services and the relationship between provider and recipient, both of which factors can be modified to use aspects of the client's culture and therefore treat him or her more effectively. Extensive lists of references are included. (PS)

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National Institute of Mental Health

Mental Health Research & Practice in Minority Communities

Development of Culturally Sensitive Training Programs

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

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MENTAL HEALTH RESEARCH AND PRACTICE IN MINORITY COMMUNITIES: DEVELOPMENT OF CULTURALLY SENSITIVE TRAINING PROGRAMS

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A number of individuals were instrumental in assuring the successful development and implementation of the symposium that served as the basis for this monograph. While the faculty of the School of Social Welfare at UCLA as a whole participated actively in the symposium, special appreciation is expressed to Professor Jerome Cohen for his leadership in structuring the symposium's format, as well as serving as its co-moderator. Appreciation also is expressed to Elizabeth Crown Spellman for her service as symposium coordinator.

FOREWORD

A major concern of the National Institute of Mental Health (NIMH) is research on mental health service delivery problems and needs of ethnic minority populations in the United States. Compilation of findings from theoretical and applied research through forums of researchers and mental health practitioners plays a critical role in the development of the field of ethnic minority mental health. The Division of Biometry and Applied Sciences (DBAS) continues to recognize and support efforts targeted at addressing these issues.

This monograph was designed to identify research findings and mental health intervention strategies that have proven effective in developing culturally appropriate mental health prevention and intervention programs. An effort was undertaken to conceptualize, study and transmit cultural competence in mental health practice as a vehicle to improve professional education and training for researchers and service providers entering the field. Identification and utilization of research results for the development of science-based, service-oriented, culturally appropriate treatment modalities and professional training programs was pursued. The participating group of scholars and mental health practitioners provided a critical formulation of future improved research and research training directions in the field of ethnic minority mental health.

The use of these findings both in the service delivery system and in professional training programs remains an exciting challenge and opportunity towards advancing the field of ethnic minority mental health.

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PREFACE

Increasing racial and ethnic diversity is a given in contemporary American life. That diversity, combined with differential access to economic resources and political power, have created sharp differences in the racial and ethnic composition of different social class groupings in American society. One manifestation of that differential is the large disparity in the racial and ethnic characteristics of professional providers and service recipients in the human services. Given that reality, the exchange of professional services between persons different in race, ethnicity and cultural orientation is inevitable.

What do we know about cultural difference and cross-cultural exchange and their impact upon access to society's resources generally and to human services in particular? What utility does existing knowledge have in guiding professionals engaged in cross-cultural practice? What practice principles and what practice skills can be generated from existing knowledge for inclusion in programs of professional education and for the continuing education of members of the professional community?

The symposium whose proceedings are reported in this volume was developed by the faculty of the UCLA School of Social Welfare to address these questions, to take stock of the present state of knowledge in this field, and to initiate an intensive review of the school's own curriculum, the relevance of its current research and its continuing education programs. We are grateful to NIMH, Division of Biometry and Applied Sciences for their encouragement.

While much research has been completed and much is in progress, it is useful to take periodic stock of the major thrust of existing scholarship and to assess whether or not it is taking us in a direction that can enhance professional practice. Surely, it is not at all clear that we have, as yet, asked the important questions. Existing theory does not yet appear to have captured the range of variables essential to an understanding of diversity in American life. Social policies and programs derived from such theory are too often deficient in helping us to recognize and respond to both the assets and the deficits that "difference" implies. Generalizations drawn from the experiences of the European immigration of the late 19th and early 20th centuries seem only partly useful in guiding our responses to current migration pressures from Hispanic America and Asia.

The papers presented in this volume move us substantially ahead in taking stock of what we know and in suggesting new directions for future inquiry. UCLA is pleased to join with NIMH in bringing these proceedings to the mental health and academic communities.

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INTRODUCTION

In May 1985, the National Institute of Mental Health in cooperation with the School of Social Welfare, University of California at Los Angeles, held a three-day symposium focusing on the mental health service delivery problems and needs of selected ethnic minority populations in the United States. This workshop sought to identify those research findings and mental health intervention strategies that have proven most helpful in developing culturally appropriate prevention and treatment programs. Issues relating to cultural values and behaviors as they affect the care giving relationship and issues pertaining to the development of cooperative interrelationships between traditional mental health agencies and culturally oriented community support systems received principal attention during the workshop. In addition, issues relating to the development and/or improvement of professional training programs served as the bridge between the existing body of research and service delivery knowledge and increased sensitivity to cultural issues in the mental health field.

A select group of mental health researchers and practitioners who are nationally recognized as leaders in the development of ethnic minority mental health knowledge were invited to prepare papers that would serve as the basis for workshop interaction and development of recommendations for future directions in the field. Each author was asked to address these issues: (1) What are the specific findings resulting from research and service delivery experiences that hold potential for meeting current and future mental health needs of culturally distinct populations. (2) What research issues need to be formulated and studied to enhance future treatment and prevention activities in ethnic minority communities. (3) What is "cultural competence" in mental health practice, and how can it be conceptualized, studied, and transmitted in professional education and training. (4) How can we most effectively identify and utilize research results in developing science-based, culturally sensitive treatment modalities and professional training programs?

The workshop comprised the authors of the papers, the faculty of the UCLA School of Social Welfare, and key individuals from the UCLA campuswide community and Los Angeles County mental health system who are known for their dedication and commitment to the improvement of mental health knowledge and service in ethnic minority communities. Representatives from the Manpower and Training division as well as the Division of Prevention and Special Mental Health Programs of the National Institute of Mental Health also attended. The opportunity for individuals in research, service delivery, and educational areas to interact around a series of questions relevant to the advancement of their expertise and professional activities in minority communities served as the basic format of the workshop.

With each of the prepared papers as the focus of workshop discussions, the participants actively interacted to clarify the relationship between research findings and recommended intervention strategies; to probe clinical experiences offered as examples of culturally appropriate intervention strategies; to question the effectiveness of existing professional training programs in preparing culturally sensitive researchers and service providers; and to express concern for the perceived diminishing national attention and provision of resources in meeting the research, service delivery, and professional training needs in the minority mental health area. Workshop participants were particularly concerned with this last issue since recommendations pertaining to these other issues have little chance of being implemented if the resources required to bring them to fruition are not available.

The concept of cultural competence and how it relates to practice emerged as a key issue during the workshop. Cultural competence was seen as consisting of basic knowledge. Those elements of culture that relate to the identification of values, norms, traditions, and rituals comprise the knowledge component and represent that portion of cultural competence that can be taught or explained to someone in didactic fashion. For the most part, this component exists in some professional training programs in varying degrees. However, the multiplicity of ethnic and cultural groups that make up our society precludes a detailed study of each of them. Can there be appropriate generalizations that cut across ethnicity and culture without resorting to a number of stereotypes?

The second component of cultural competence consists of obtaining information at the feeling or emotional level. The opportunity to engage someone from another culture in relation to their day-to-day living experiences, behavior, and expectations provides the insight and empathy required in effectively understanding the psychosocial "pushes and pulls" that direct the lives of these individuals.

It is clear that knowledge and experience are required in becoming culturally competent, but frequently one occurs in the absence of the other. More often than not, professional training programs provide cultural knowledge in relation to selected variables of that culture, but provide no real opportunity to experience the culture in its "living" form. Restricting the experiental component to seeing ethnic minority clients in a clinical setting is insufficient. The client-therapist setting is frequently so constricted by defensiveness, emotional despair, and conflict of expected behaviors on both the therapist's and client's parts, that little opportunity exists for meaningful insights into the clients cultural value system. The development of opportunities that place students in normative cultural settings in addition to the clinical setting (e.g., placement in senior citizen centers, community social action groups) would significantly enhance the experiental component of cultural competence.

In addition to placing the student in the community, bringing the community to the student serves as an alternative or supplemental approach in enhancing the experiental component of cultural competence. Cooperative developments between educator, practitioners, and community "cultural brokers" (e.g., community leaders and social activists) should assist in determining what cultural practices are important to understand and how these practices should be implemented into the curriculum.

Workshop discussions also centered on more theoretical notions about the development of cultural competency, and participants pointed to the possibility of organizing cultural competence in a variety of ways. How significant is it that the student be knowledgeable about and have had experience with a particular cultural group as opposed to being able to relate to a particular life situation (e.g., refugee status)?

Should cultural competence be organized around issues of life style, social class, immigration status, discrimination, and unemployment? Other questions raised during the conference included ethnic matching, the use of diagnostic instruments based on majority group norms, and the ever-present need for a clarification of the concept of cultural competence.

There was general agreement that "cultural competence" meant placing one's abilities at the service of the client. But, how do professionals place their knowledge and experience at the service of specific populations whose access is underrepresented. The question is complicated by the multiplicity of ethnic and cultural groups that make up our society and the limited number of professionals who have the knowledge and experience to deal with them.

Obviously, appropriate responses or solutions to these issues lie ahead of us. Each of the chapters included in this text provides some insight into these issues, but none possesses the complete response. Further conceptualization and research provide the truest path in successfully responding to the issues.

OVERVIEW

This volume covers two major areas. Chapters 1 through 5 were developed by mental health researchers with an academic and/or a theoretical perspective in discussing the significant variables to be considered in developing culturally sensitive training programs. Chapters 6 through 10 represent the work of mental health clinicians and administrators (with the exception of S. Sue) who draw from their extensive experiences in providing culturally appropriate service and training programs in meeting the needs of American minority populations. The authors have attempted to approach their subject matter using an integrated and systematic framework.

Chapter 1, "The Cultural Context of Diagnosis and Therapy: A View from Medical Anthropology" by Good and Good, states that when dealing with ethnicity and mental health, medical anthropology has focused almost exclusively on popular or folk beliefs, on culture-specific folk illness categories, and on native healers. Within the past decade, a new paradigm of medical and psychiatric anthropology has emerged from the work of anthropologists and clinicians conducting research in clinical settings, drawing on new theoretical frameworks from interpretive anthropology. In general, two distinctive issues have emerged.

First, work in cross-cultural settings has raised questions in relation to the validity of some of the newly developed psychiatric diagnostic criteria as represented in the Diagnostic Statistical Manual III (DSM-III). Additional, epidemiological instruments (e.g., the DIS) when used with culturally distinctive groups leave much to be desired in terms of interpretative validity of the results. Research is presented demonstrating major variations in symptom presentation and "illness discourses," challenging the assumption that specific symptoms will be uniformly associated with diagnostic entities across cultures. Evidence for their argument is reviewed, and suggestions for research are outlined.

As a second issue, current work in this area has increasingly focused on cultural issues in therapeutic process. The authors' work in a cultural consultation clinic in California indicates that symbolic and interpretive processes play a central role in (1) the establishment of intimate therapeutic relationships, (2) in the control of "effective distance" in therapy, (3) in the development of metaphors critical to healing, and (4) in issues of reflexivity and countertransference that emerge in therapy. The chapter provides an excellent review of each of these issues.

Chapter 1 concludes with a proposal for the development of a new "cultural axis" for DSM-III, which would serve as a research axis to stimulate further investigations of the issues raised in this work.

Chapter 2, "Cross-Cultural Competence in Minority Communities: A Curriculum Implementation Strategy" by Valle, stresses that cross-cultural competence is best conceptualized as the ability of the practitioner or researcher to demonstrate an effective understanding of the symbolic systems and their interactional patterns within a culture, as well as the values and beliefs accompanying those systems. The author suggests that despite knowledge development over the past two decades, cross-cultural competence has not been systematically incorporated within professional mental health training programs. Four major barriers contributing to this problem are discussed.

First, cross-culture competence remains uneven throughout the field of mental health; the sources of such knowledge cannot always be generalized. Second, the field lacks the data base capable of establishing valid criteria for what constitutes cross-cultural competence in each of the major mental health professions. Third, the field has not effectively addressed the key "politics-of-knowledge" issues that accompany curriculum change in the mental health profession. Fourth, the resistance to change by individual mental health practitioners and researchers continues to be one of the more formidable obstacles to implementing cross-cultural knowledge and competence development.

As a way of eliminating obstacles to the development of cross-cultural competence, the author addresses the need for carefully developed curriculum changes that build around ongoing cross-cultural research efforts. Early development of working relationships between researchers and educator/practitioners is suggested to facilitate incorporation of research findings into development of training modules at both the didactic and experiental levels. Social network systems are used as an exemplary area from which to develop cross-cultural training models.

Chapter 3, "Recent Advances in American Indian Mental Health Research: Implications for Clinical Research and Training" by Manson, indicates that treatment issues are yielding to a growing interest in preventive strategies. The chapter emphasizes the tremendous diversity among the American Indian populations and the long period of Federal responsibility, which has included legal and moral intervention.

In terms of mental problems and needs, the chapter points out that studies indicate alarmingly high rates of psychological dysfunction and major mental disorder exist within this population, with depression, adjustment reactions, and suicides as areas of special concern. The problem of drug and alcohol abuse varies greatly among tribes.

Treatment studies have concentrated on themes emphasizing indigenous religions and ceremonial activities, different cultural values, psychoanalytic explanations of individual responses to stress, and the role of traditional healers and the structure of formal mental health delivery systems. There are a lack of systematic studies concerning the effectiveness of these approaches.

The chapter poses a number of questions involving diagnosis and assessment, treatment, and prevention. In the area of diagnosis and assessment, some of the questions relate to Indian definitions of psychological dysfunction and mental disorder; the correspondence between their definitions and the DSM-III classifications; and the reliability and validity of prevailing diagnostic instruments used on the Indian population. Relevant questions concerning treatment include appropriate treatment modalities, discrepancies of expectations between therapist and Indian clientele, measurement of treatment outcome, and the role of indigenous treatment techniques and appropriate goals.

The chapter concludes with a discussion of how prevention-related research raises questions as to what problems may be preventable and by what techniques, appropriate assessment of interventions, what models are appropriate for different tribes, and the most effective means of educating individuals and communities as to the importance of preventive and promotive efforts.

Chapter 4, "Findings From a National Survey of Black Mental Health: Implications for Practice and Training" by Jackson, Neighbors, and Gurin, presents data obtained from a national survey conducted in 1980 addressing some of the major deficiencies in previous research on mental health functioning and help-seeking among black Americans. The chapter points out that previous research in this area has been hampered by a lack of awareness and appreciation for the unique cultural experiences of blacks and the poor conceptualization of relevant models; by an emphasis on race comparative studies with little theoretical or empirical concern for appropriate methodological development in studying different cultural groups; by a lack of attention to obtaining reliable and valid mental health measures; and by a lack of adequate data on large representative samples of black Americans.

The chapter discusses findings that explore the personal problems experienced by the study's sample population, which comprised 2,107 black adults. Additionally, data relating to the reactions to these problems, individual coping strategies employed, and the use of informal supports and professional resources are presented. The chapter also suggests how to increase the viability of mental health service delivery as this relates to significant social and cultural factors identified in the research data. The relationship of these factors to the development of culturally sensitive training models serves to conclude the chapter's goal of bridging the gap between research activity and service in the mental health field.

Chapter 5, "Making Effective Use of Research to Impact the Training of Culturally Sensitive Mental Health Workers" by Casas, points to the continuing lack of attention given by most mental health training programs to the existence of ethnic minority groups and their unique mental health needs. The author suggests that, given the changing racial/ethnic demographics in this country, the mental health profession can no longer continue to ignore these groups within the realm of training.

Working from this perspective and drawing specifically from the author's previous research in the area of Mexican American mental health issues, Casas exemplifies the manner in which relevant research findings can be integrated into mental health training curricula to enhance sensitivity towards ethnic minority clients. To attain this objective, the chapter identifies the characteristics or competencies that training programs should seek in developing culturally sensitive mental health professionals. The chapter concludes with an examination of the mechanisms that training programs can use in assessing cultural competence and sensitivity, as well as developing recommendations for directing both research and professional policy toward the establishment of training programs that produce culturally sensitive professionals.

Chapter 6, "Hispanic Human Resource Issues: A Reassessment of Mental Health Manpower Needs" by Quiroz, points to the necessity of redefining the underlying premises guiding the training and utilization of minority professionals within the mental health system. Long-standing assumptions that minority communities require different forms of intervention techniques and treatment modalities have frequently resulted in minority researchers and practitioners alike having to prove the existence of these special needs before resources to enhance access to minority communities could be allocated.

The author suggests that the real issue may stem from a rigid service delivery system unable to effectively deal with an increasingly diverse client population with varied needs. In addition to increasingly diverse cultural needs, the growing percentage of the client population labeled as severely and chronically mentally ill calls for a reconceptualization of professional training needs and service distinction. Crisis management stabilization, brief therapy models, case management techniques, and support services are mentioned as potentially providing the framework for the development of effective services to these increasingly diverse and chronically disabled populations.

The need to strengthen the relationship between academic institutions and the field of practice is discussed, particularly as this relates to the types of applied research capable of defining what is meant by "culturally appropriate intervention strategies" and how these strategies should be assessed for effectiveness. Additionally, it is suggested that when such research is undertaken, policy implications for resource allocation and changes in the service delivery system must follow.

Chavez, in Chapter 7, writes about the delivery of services to Hispanic populations in "Mental Health Delivery to Minority Populations: Hispanics--A Perspective." She sees effective delivery as a combined function of cultural attitudes, service parameters and delivery processes, and a particular chemistry that develops between provider and service recipient. The balance is seen as a delicate one, where a break in any link of the chain could lead to failure to deliver effective services.

The goal of training is to provide therapists who are sensitive, competent, and willing to facilitate the problem-solving process. Bilingual, bicultural gaps must be broached; sensitivity must be established, not only for the individual non-Hispanic therapist, but in terms of the manner in which the service is offered and the design of the knowledge base. The author emphasizes that true cultural sensitivity goes beyond academic learning; it entails experience and absorption. Also, she advocates the use of videotapes as a means of gaining experience.

Chapter 8, co-authored by Sue and Zane, is entitled "Therapists Credibility and Giving: Implications for Practice and Training in Asian-American Communities." The article concentrates on problems of service delivery and treatment. Asian-Americans in a college treatment facility were severely underrepresented, more clinically disturbed, and more likely to attend fewer therapy sessions than non-Asian students. The authors feel that the differences may be due to the perception of Asian-Americans that psychotherapy is useless, foreign, and stigmatizing, and that only individuals with severe problems would tend to use psychiatric facilities. The high rate of premature termination was attributed to the clash of Asian cultural values with those of mainstream American values, as typified by Western-trained therapists.

Treatment should match or fit the cultural lifestyles and experiences of clients. Knowledge of Asian-American cultures, including language facility, and modification of traditional forms of treatment is helpful. However, given the diversity of Asian-Americans and the variety of therapeutic models, the task of training and of devising appropriate treatment procedures appears almost insurmountable.

The authors suggest a way out of the dilemma, through the establishment of credibility. Outcomes are better when the client believes in the therapist and in the methods being employed. Ascribed and achieved status are important variables in establishing credibility. Age, sex, degrees, position, status, and skills are related to ascribed credibility. Achieved credibility is related to the ability to accurately conceptualize problems, to provide the means for problem resolution, and to establish realistic goals for treatment. There is an intimate interaction between ascribed and achieved credibility.

Wong, in Chapter 9, writes about "Mental Health Services in Asian and Pacific Asian Communities: Directions for Training Programs and Curricula." He indicates that at least 32 distinct ethnic and cultural groups fall under the umbrella of Asian/Pacific Americans. The pooling of the separate and distinct cultures under the one label emerged in part out of political necessity, as individual numbers were far too small for meaningful representation in the political arena.

Although the Asian/Pacific Islander label is a convenience, it ignores the different histories, cultures, and languages of each of the groups. How does one train for such diversity when the goal is to provide better mental health services. The author lists 17 important differences, including demographic variables (i.e., age, sex, social class background, religion, education, income prior to the time of arrival), family composition, migration and relocation experiences, identification with the home country, and value orientations. Sensitivity to the ethnic, cultural, and linguistic diversity of Asian/Pacific Americans will be the key factor in providing successful mental health services.

Wong also indicates that American mental health concepts and techniques are foreign to many of the Asian/Pacific groups. Clinical psychology and psychiatric social work as professions are not a part of their cultural orientation. Therefore, there may be little understanding and little value placed on talking about problems, especially with a stranger, on self-disclosure, and analysis of one's private thoughts. Professional intervention may be interpreted as meddling.

Finally, for many recent immigrants, especially refugees from Southeast Asia, relocation and resettlement has been associated with extremely traumatic experiences. Treatment must take into account the recentness of some of these experiences and the importance of providing ongoing supervision and support to mental health providers handling these problems.

A number of recommendations are made, based on reports of a number of Asian American groups. They include significant participation of Asian/Pacific Americans on all levels of decision making and program participation, better coordination of programs, funding of bilingual and bicultural programs, support of prevention efforts, and the creation of ethnic community-based training and service consortiums.

Bestman, in Chapter 10, focuses on "Cross-Cultural Approaches to Service Delivery to Ethnic Minorities: The Miami Model." The article assessess the effectiveness of a research project developed by the Department of Psychiatry of the University of Miami to study and understand cross-cultural differences in health beliefs and practices. The study concentrated on five major ethnic groups represented in the Miami area: Cubans, Black Americans, Haitians, Puerto Ricans, and Bahamians.

Preliminary findings indicated significant underutilization of social service institutions by these groups, stemming from a variety of factors such as lack of bilingual staff for the multiethnic and multicultural population. Other factors included lack of people's awareness of the programs, lack of transportation, distrust, and culturally determined attitudes conflicting with the backgrounds of residents.

There were also culturally patterned differences in perceiving the prevention, cause, and remedy of illness, including mental illness. The findings suggested that a community mental health center established along traditional mental health lines would be ineffective; what was needed was a new approach using community-based ethnic teams possessing the knowledge and experience to deal with mental health problems in a community and cultural context.

A model was developed to provide accessible, culturally relevant services and to help alleviate environmental stress by ensuring that area residents would receive their full share of resources.

Direct service was sensitive to cultural variables. A wide range of therapeutic resources was made available, including *obeah* for Bahamians; *vodum* or voodoo for Haitians; *rootwork* for southern Blacks; *santeria* for Cubans; and *espiritismo* for Puerto Ricans.

Knowledge and awareness of a client's culture was seen as essential. Client beliefs often conflicted with the views of professionals who were trained in Anglo, Western-oriented health systems. However, the author warns against a wholesale adoption or application of any one explanatory system for all individuals of a particular group.

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CHAPTER 1

THE CULTURAL CONTEXT OF DIAGNOSIS AND THERAPY:

A VIEW FROM MEDICAL ANTHROPOLOGY

Byron J. Good, Ph.D. and,
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INTRODUCTION

Traditional medical anthropology dealing with ethnicity and mental health care focused almost exclusively on popular or folk beliefs, on culture specific folk-illness categories, and on native healers. This work had important strengths. It challenged the prevailing assumption that professional psychiatric clinics are the mental health providers in a community, focusing attention on the variety of popular care providers in a community, including families, traditional practitioners, social service agencies, religious specialists, and others who provide social support and treatment to the mentally ill. Traditional medical anthropology also drew attention to the ethnocentrism and racism embodied in the general assumption that common Anglo-American patterns of expressing distress and seeking treatment should be considered normative and that distinctive illness forms or culture-specific therapies of particular ethnic groups represent developmentally prior or inferior patterns of psychological or cultural functioning.

On the other hand, by the late 1960s, much of the work of anthropologists seemed ethnocentric in its own way. Ethnicity was often analyzed by anthropologists in "belief" terms: an ethnic group, it was held, can be identified by its distinctive set of beliefs, especially about the cause of illness and the appropriate means of its treatment. Given the great diversity of members of any ethnic community and the rapid cultural change within communities, such accounts increasingly appeared as stereotyped characterizations, even when researchers indicated the particular subcommunity from which the data were drawn. Furthermore, anthropologists often seemed almost exclusively interested in exotic, even rare, aspects of culture--"folk illnesses" and traditional healers, in particular--rather than either the clinical or the social, political, and economic issues that play a critical role in the lives of persons seeking mental health care. Cultural issues in diagnostic work and psychotherapy, for example, were seldom the focus of anthropological research and writing.

If a rather narrow focus on folk culture has often limited the relevance of anthropologists' work for clinicians, so too have the questions put to those anthropologists who began working in clinical settings. Several years ago in a course we were teaching on culture and mental health care to third-year residents in a department of psychiatry in California, a psychiatric resident put to us a question we were to hear over and over again. "We don't want to know about social theory or about foreign cultures," he said. "Just tell us what is relevant for treating the patients we are most likely to see. What do we need to know about blacks, Mexican Americans, and Asians? What are their most important beliefs? What are the special tricks we need to know to do successful therapy with them?" Such questions place anthropologists in a kind of double bind. The immediate impulse is to respond that one cannot characterize the beliefs or patterns of interaction of any entire ethnic group, including Anglo-Americans, without maintaining and teaching stereotypes. Such a response, however, seems to imply that cultural differences are not important or cannot be conveyed in a manner relevant to the clinician. This too flies in the face of what the anthropologist believes. There is an enormous literature on the cultures represented by American immigrants and minorities, and it is our experience that a depthful understanding of culture is critical to empathic and successful clinical work. So what is the response to the resident's questions?

This paper grows out of several years of experience of not only trying to teach in a maner that gives relevant answers to these questions, but also attempting to reformulate the questions that are important to ask. We spent 7 years as members of a department of psychiatry in California teaching residents, clinical psychologists, and medical students. We were often called to consult in cases involving Middle-Eastern, especially Iranian, patients. We spent 1 year working with a Mexican-American psychiatrist, Dr. Henry Herrera, in an experimental "cultural consultation clinic," seeing Hispanic patients along with spiritualist healers from the community. We are currently directing a postdoctoral research training program in clinically relevant medical anthropology. In each of these settings, several questions about the relevance of anthropology for clinical practice in multicultural contexts have been central to our work. What is different about the way someone who is "culturally competent" evaluates or diagnoses a patient and conducts psychotherapy, in contrast with someone who is not? For example, when we are called to consult with cases involving patients from a culture we know well, what are we able to do that others are not? For what aspects of diagnosis and treatment does cultural competence really make a difference? Can a clinician be taught to do those things that a good clinician from within the culture does naturally? Are years of learning about a particular culture necessary, or can we identify general skills or approaches to therapy that may make a therapist better able to function in multicultural settings? What are the critical research areas that can advance our understanding of these issues?

Several developments within psychiatry and anthropology since the 1960s have altered the context for discussing these issues. Within psychiatry, diagnosis has become a more central activity. When few effective medications were available for treatment of the mentally ill, diagnostic characterizations made relatively little difference in treatment. The emergence of medications for the affective disorders to complement anxiolytic drugs and the major tranquilizers, and the discovery that some drugs have "paradoxical" effects (for example, that antidepressants are effective in treating at least one form of anxiety--panic disorder), have focused enormous research attention on diagnostic criteria. Such work continues to provoke heated debate about the extent and consequences of misdiagnosis, especially in public care facilities (Lipton and Simon 1985). In this context, the possibility that diagnostic criteria may be culturally relative, that criteria for a disorder such as depression may vary across cultures or ethnic groups, has far more importance than it did 20 years ago. At the same time, increasingly complex research within social psychiatry is provoking new hypotheses about the social origin and consequences of psychopathology, many of which implicate culture-specific features of social organization (kin patterns, social support, and the perception and evaluation of stressors) and require sophisticated analysis of culturally distinctive social groups. Thus psychiatric knowledge has supported a more sophisticated view of both biologically grounded disease phenomena, with important implications for diagnosis and prescription, and the social production of illness phenomena.

Anthropology too has changed in the past two decades. While lively debate continues among materialist, cognitive, structuralist, and psychoanalytic theorists, "interpretive" anthropology has emerged as an important theoretical paradigm. Within medical and psychiatric anthropology, interpretive or meaning-centered theorizing has been wedded with new attention to clinical phenomena to produce an increasingly sophisticated literature. In general, leading figures within this paradigm reject both a "health belief" approach, which characterizes individuals or groups in terms of a distinctive set of beliefs, and a personality approach, which hypothesizes a distinctive personality type for members of a particular cultural group. Focus is rather on the "social production" and "cultural construction" of illness (e.g., Kleinman 1980, Kleinman et al. 1977, Marsella and White 1982), on the use of culturally distinctive meaning systems to interpret personal and social realities (e.g., Good 1977; Good and Good 1981, 1982; Young 1976), on cultural idioms of distress and modes of discourse (Nichter 1981, Csordas 1983), and thus on processes through which forms of illness are generated, constructed as social realities, and maintained or treated. The primary object of analysis, from this perspective, is neither the typical personality of a group nor the beliefs typical of its members, but the meanings through which both are fashioned. As Geertz (1973, p. 5), one of the leading advocates of this perspective writes: "Believing, with Max Weber, that man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning." This also has been the belief of interpretive medical and psychiatric anthropologists.

In this paper we will argue that an interpretive or meaning-centered anthropology provides a critical perspective on unresolved issues facing clinicians, teachers, and researchers working in multiethnic and cross-cultural settings. Anthropology's distinctive focus on "local" discourse and knowledge (cf. Geertz 1983)--on individual clinical phenomena, on the complex relations among public and private meanings of symptoms and complaints, on the struggle to come to understanding and to impose authoritative interpretations on such phenomena, and on the social sciences as yet another form of interpretation--provides an important vantage for viewing clinical work and methods appropriate to its analysis. We hope to show that research from this perspective raises serious questions about the direction of much of current psychiatric research and practice. In the remainder of this paper we focus on two issues: the role of cultural differences in psychiatric diagnosis and the implications of such differences for psychotherapeutic process. Equally important issues concerning the social origins and consequences of mental illness are not addressed here.

THE CULTURAL CONTEXT OF DIAGNOSIS

A wide variety of publications over the past two decades indicate that the diagnosis a patient receives is closely linked to his or her ethnicity and social class. Some studies provide convincing evidence that certain minority populations, owing to substantial social inequities, are at very high risk for particular disorders. For example, the prevalence of depression may be four to six times higher within select Indian communities than that observed for the U.S. population at large (see Manson et al. 1985 for an overview). Other studies indicate that misdiagnosis of minority patients is extremely high in certain clinical settings, probably because of biases implicit in the client-therapist transaction. The most classic examples of this are findings that hospitalized blacks are far more commonly diagnosed as schizophrenic and rarely diagnosed as depressed, in comparison with whites in the same institutions, and that rediagnosis using research diagnostic teams eliminates these differences (Simon et al. 1973, Raskin et al. 1975; see Adebimpe 1981 for an excellent review). A majority of studies in the field, however, are much more difficult to interpret. Are differences in levels of psychopathology among various ethnic groups a result of *actual* differences in incidence and prevalence of psychiatric disorders, or do they result from biases in the diagnostic process or the research instruments being used?

To provoke our thinking, it may be useful to recall the findings of the famous Midtown Manhattan Study. This study did not specifically sample from strata defined in ethnic terms; however, when the small, naturally occurring Puerto Rican sample was analyzed separately, not one person was rated "well" and 52 percent were rated "impaired," a rating assigned to only 23 percent of other persons in the study (Srole et al. 1972, p. 291). These findings are particularly difficult to interpret. Are high rates of symptoms among Puerto Ricans, a finding replicated in other studies (e.g., Abad and Boyce 1979), evidence for higher rates of psychopathology, or do they simply indicate a difference in styles of communicating distress? Do other studies that find differences in rates of symptoms or diagnoses across ethnic groups [e.g., Kuo 1984, Vernon et al. 1982, Roberts 1980, Quesada et al. 1978; see also reports on differences among blacks and nonblacks in the recent ECAC studies (Robins et al. 1984)] reflect actual differences in prevalence of mental illness or are the findings artifacts of the research instruments employed? Do these studies indicate actual differences among groups in level of distress, produced by social inequities, or do they represent differences in judgments made by clinicians representing mainstream American culture or psychometric instruments that replicate such biases in judgment? In addition, do findings such as those of the Midtown Manhattan Study that *social functioning* varies across ethnic groups reflect differences in actual levels of functioning, or are they also a result of biases in the judgments made by the raters? This latter issue takes on special significance in light of recent findings that hospital admission correlates more closely with practitioner's evaluation of level of functioning (axis V) than with diagnosis (Mezzich et al. 1984).

The problem of establishing validity of psychiatric diagnosis and assessment, and the associated problem of training clinicians to make correct diagnoses in cross-cultural and multiethnic settings, is an essential problem; it is inherent in the enterprise and is not simply a matter of bias or technique. As with many of the phenomena anthropologists study across cultures, there simply is no "gold standard" for psychiatric assessment. Recent efforts to use Research Diagnostic Criteria and the Diagnostic and Statistical Manual III (DSM-III) criteria as the "gold standard" are clearly an advance in providing grounds for overcoming bias. However, the DSM-III relies on symptom criteria; if the content and frequency of symptoms vary across cultural groups, diagnosis using these criteria will be strongly affected. What evidence do we have? Do symptoms vary systematically across cultural groups? Are differences significant enough to produce systematic bias in diagnosis? How does this source of bias relate to that resulting from clinicians' attitudes toward, or ways of communicating with, clients from particular ethnic groups or social classes?

In the following two sections we will examine the question of diagnostic bias and raise the issue of the indeterminacy of diagnostic criteria. We will conclude by arguing for a cultural or interpretive understanding of the relation of symptoms to psychiatric illness and outline issues for research and training that follow.

Culture, Race, and Bias

Considerable evidence indicates bias on the part of the clinician influences diagnostic judgments that are made. Before reviewing this issue, a few words are in order about its significance. Whether in matters of research or teaching, why should we be so concerned about psychiatric diagnosis?

As we described in the introduction to this paper, the past 15 years have seen dramatic changes in methods of assessment and diagnosis of mental illness. Whereas diagnosis was once primarily the domain of theoreticians rather than practitioners, the discovery of psychoactive drugs that have differential effects upon particular psychiatric conditions lent urgency to efforts to establish valid and reliable criteria for psychiatric diagnosis that would be an important part of routine clinical work. Such efforts resulted in the DSM-III and in associated epidemiological instruments (see Weissman and Kleran 1978 and Murphy 1982 for excellent reviews of changes in epidemiological research). The widespread use of these medications and the discovery that the diagnoses upon which their prescription is based varies enormously from country to country--in particular that American psychiatrists vastly overdiagnose schizophrenia (Cooper et al. 1972)--led to major efforts not only to establish validity of diagnosis but also to increase adherence to these criteria in actual practice. Such efforts were spurred on by awareness of the enormous iatrogenic effects of psychiatric medications, in particular the major tranquilizers.

Recent research indicates that in many clinical settings, diagnostic style has not changed nearly as much as this history would lead one to believe. For example, a recent study in part of the same hospital system in which the study by Cooper and his colleagues (1972) was conducted, the Manhattan Psychiatric Center, found that as many as 75 percent of all patients may be misdiagnosed (Lipton and Simon 1985; cf. Goleman 1985). Whereas hospital diagnoses showed 68 percent of patients with schizophrenia and 12 percent with affective disorders, the research team found that only 12 percent met criteria for schizophrenia while 38 percent met criteria for affective disorders. Thus, failure to use new criteria for psychiatric diagnosis and prescription of medication appears to be widespread, even to this day, at least in public institutions.

Why should social scientists interested in mental health practice and research in minority communities take special note of such a finding? First, it should be remembered that minority persons are disproportionately represented in public clinics and the public hospital system, and that members of various ethnic groups have quite different hospitalization rates. Any negative effects of misdiagnosis will thus bear most heavily on those overrepresented groups. Second, differential diagnosis is closely linked to medication practices. The diagnosis of schizophrenia is routinely followed by treatment with neuroleptics, prescribed, as Lipton and Simon (1985, p. 371) point out, "in doses sufficient to 'quiet' the 'disturbing' symptoms." Tardive dyskinesia, a significant complication of neuroleptics, may be found in as many as 30 percent of persons using antipsychotic drugs. In addition to increasing social dysfunction and representing the clearest evidence to the patients that they are "crazy," tardive dyskinesia seems to increase risk for disease and suicide (Lipton and Simon 1985, p. 371). Thus, not only are persons suffering from depression or manic depressive disorders prevented from receiving effective treatment, they are also treated with drugs having very significant iatrogenic effects. Third, mislabeling individuals "schizophrenic" is likely to have profound effects on their life course. Hospitalization is likely to be vastly lengthened, medications are likely to mask symptoms of manic or depressive episodes, as well as of organic disorders, and the risks of chronic institutionalization and social breakdown syndrome are dramatically increased. While much of the debate of the late 1980s around social labeling was probably misplaced, given its focus on deviance and its questioning the existence of mental illness as disease, clearly misdiagnosis has many of the deleterious effects associated in that literature with labeling. Because these issues so profoundly affect members of minority groups, it is worth giving special reconsideration to the issue of misdiagnosis.

While misdiagnosis seems very high among all ethnic groups in some clinical settings, there is what Adebimpe (1981) in an interesting review describes as "a modest body of circumstantial evidence" that members of minority subcultures are at a particularly high risk for error in diagnosis and assessment. Several explanations run through the literature. First, cultural differences associated with language, modes of expressing symptoms, meanings associated with experiences such as altered states of consciousness, typical idioms of distress, sociolinguistic patterns, and differences in explanatory models and value systems is often reported to lead to unintended but systematic bias in assessment and diagnosis of persons from very different life worlds than that of the clinician. Second, both institutionalized racism (Hankins-McNary 1979) and cultural stereotypes translated into psychiatric language and maintained by clinicians have been found to influence assessment. Stereotyped images of blacks as "jovial" may in part account for the widespread impression of low levels of depression (Adebimpe 1981, p. 281); images of Puerto Ricans or blacks as lacking impulse control or having primitive character structure translates cultural differences into normative psychiatric language and can only lead to more severe diagnostic ratings (Sabshin et al. 1976, Abad and Boyce 1979); and views of somatization as a primitive defense system, rather than a cultural idiom, has led to readiness to assume many are inappropriate for psychotherapy. Third, related to this problem, are reports of culturally based forms of transference and countertransference that strongly influence the nature of clinical presentation, especially during initial stages of evaluation and therapy, and that influence the judgments made by therapists (e.g., Ticho 1971). For example, the clinical expression of hostility and other affects is influenced not only by cultural patterns of expressing emotion, as greatly as these vary across cultures, but by implicit rules for cross-ethnic communications; Carter (1974), for example, cites the "masking" of self and affect as a historically grounded "survival mechanism" and notes the special fears associated with black patients' expression of hostile or aggressive feelings to white therapists. On the other hand, clinicians often have relatively little experience dealing with patients of other ethnic groups (Jones and Gray 1985), and, because of their own discomfort, often engage unknowingly in ways of relating that play out stereotypical images and expectations (see Maduro 1975 for perhaps the best case report and analysis of this phenomenon in the literature). Individual clinicians may respond in various ways. Beiser (1985) reports that young psychiatrists stationed in the Indian health services tend to respond in two ways. Some become rigidly and authoritatively "medical," dismissing beliefs and values of patients and concentrating on disease. Others become enamored with native culture and rationalize symptoms rather than recognizing them as signs of illness. This results from a process similar to that reported by McDermott (1967), who found that physicians underdiagnose organic brain conditions in children from lower social classes because they believe the symptoms to be the result of cultural deprivation that the children will "grow out of."

From an anthropological perspective, these biases in the diagnostic process are not simply aberrations or biases based in attitudes of practitioners; they are examples of a more general process that is often hidden from view when clinician and patient are from a similar culture and social class. All diagnostic and therapeutic encounters are transactions across distinctive subcultures and are embedded in local systems of power relations. Not only do clinicians as individuals belong to particular subcultures, their theoretical position itself is a cultural form and one that incorporates a set of values, explanatory models, "structures of relevance," and ways of interpreting the discourse of patients. A psychoanalyst, biomedical psychiatrist, and family therapist will interpret a particular symptom from a radically different vantage. In addition, individual background and culture influence the assessments made, even when explicit diagnostic paradigms are used. Gaines (1979), for example, shows to what extent the implicit paradigms or models of psychiatric residents influence their decisions in emergency rooms. Thus not only do clinical algorithms and explanatory models frame diagnostic judgments, but the personal meanings associated with these models and with the issues raised by the patient's distress influence those assessments as well. What psychiatric theory analyzes as transference and countertransference are particularly important subtypes of more general cultural phenomena that have been the focus of interpretive anthropological studies (e.g., see Good et al. 1982, 1985).

Several important training issues emerge from a view of clinical practice as transactions across distinctive cultures. First, clinicians in training should be encouraged to develop explicit awareness not only of their own psychological responses, which is a goal of most programs, but of unexamined aspects of their working clinical knowledge, its relation to their own subculture, and the personal meanings with which they invest their clinical paradigms. Second, clinicians should be taught to elicit and identify critical aspects of the patient's culture--the explanatory models of patients and their families, the popular illness categories used to identify aspects of their condition, and the meanings associated with particular affects or symptoms. Third, the role of culture and acculturation in transference and countertransference phenomena should be addressed explicitly in clinical training. Individuals establish personal identity in relation to society; for members of immigrant groups or distinctive subcultures, identity in relation to the dominant culture is often problematic. Individuals may identify themselves as traditional, as bicultural, as adherents of a distinctive ethnic identity, or as fully acculturated members of the dominant culture, or may have different identity strategies in various domains of their lives. A clinician can never be neutral in relation to the client's stance toward the dominant culture; the therapist will always represent, to some extent, a particular aspect of that culture. Self-presentation of the client during assessment and therapy will thus reflect a particular stance toward mainstream culture, and the data upon which assessment is based will thus be grounded in a particular subjective stance toward what the clinician represents.

The anthropological perspective on diagnosis raises even more fundamental questions, however. If diagnosis is always an evaluative transaction across systems of meaning or culture, how can we be certain that such cross-cultural interpretations (i.e., diagnoses) are valid? How can we be certain we are not committing a "category fallacy"? In a cross-cultural context, a category fallacy is the reification of a nonsological category developed for a particular cultural population and the application of that category to members of another culture without establishing its validity for that culture. Having dispensed with indigenous categories because they are culture specific, psychiatrists and researchers often go on to impose their own "scientific" categories on some sample of behavior in another culture as if their own disease categories were culture free (Kleinman 1977; cf. Good and Kleinman 1985b). Does this fundamental problem in cross-cultural psychiatry also plague diagnostic work and epidemiological research with American minority groups?

The Indeterminacy of Diagnostic Criteria

As we argued earlier in this paper, we believe the establishment of explicit diagnostic criteria, such as those found in DSM-III, provides an important advance over previous approaches to diagnosis and, if applied in a reliable manner, should reduce bias in cross-ethnic situations. On the other hand, DSM-III and the associated diagnostic instruments, such as the Diagnostic Interview Schedule (DIS) of the National Institute of Mental Health, are currently being translated into various languages to serve as the basis for making comparable diagnostic and treatment decisions. For example, the DIS has been translated for use among Mexican Americans (Hough et al. 1983) and several native American groups (Manson et al. 1985). Such an approach to translation must assume not only that psychiatric disease categories are universal, but that symptoms that serve as diagnostic criteria are also, with minor variations, universal. Current work in medical and psychiatric anthropology suggests several problems inherent in the translation of symptom criteria for use in another culture, whether in clinical practice or in research. We will briefly review five.

The Problem of Normative Uncertainty. "Cultural anthropology, if properly understood, has the healthiest of all skepticisms about the validity of the concept 'normal behavior,'" wrote Edward Sapir (1970, p. 150) in 1932. "It cannot deny the useful tyranny of the normal in a given society, but it believes the external form of normal adjustment to be an exceedingly elastic thing." We now know that many mental health problems are more disease-like than Sapir and his psychoanalyst friends believed in the 1930s, that certain forms of disordered experience appear quite similar across cultures and universally cause suffering. At the same time, however, one of the major difficulties facing any clinician working with a patient whose culture is different is to determine whether particular behaviors or forms of experience are abnormal and therefore a symptom of illness or simply different but normal within the patient's own cultural context. Is there a cultural basis for explaining why the mother of a hospitalized Iranian patient is spending 15 hours a day in the waiting room outside the psychiatric unit, we were asked, or is this a sign of a pathologically enmeshed family relationship? (See Good and Good 1981 for analysis of this case.) Is the complaint of a Puerto Rican woman that she has suffered an ataque, which included momentary loss of consciousness, a symptom of a neurological disorder, a culturally labeled panic attack, or simply a culturally normal--though troubling--response to an acutely stressful situation? Given great differences among the ways members of various cultures experience and communicate emotion, how should the clinician determine whether a Vietnamese or American Indian patient meets the criterion of "dysphoria"? May the presence of altered states of consciousness, even when intrusive and unwanted, be normal rather than pathological in some societies? For example, Liss and his associates (1973) found that delusions and hallucinations were associated with a definitive diagnosis of schizophrenia among white but not black patients, indicating these symptoms do not have the same diagnostic import in the latter (Adebimpe 1981, p. 282).

If the problem of determining whether a particular behavior or a particular level of distress should be considered normal or symptomatic is difficult for clinicians, it has been a plague for cross-cultural psychological studies. Studies using psychological scales, such as the State-Trait Anxiety Inventory (see Spielberger and Diaz-Guerrero 1976), have been remarkably ambiguous as to whether differences in scale scores across cultures should be interpreted as differences in what is normal for a group (i.e., the norm, a characteristic response pattern of a normal population) or represent actual differences in levels of distress or pathology in the groups studied (for a review of cross-cultural psychological studies of anxiety, see Good and Kleinman 1985b, pp. 300-303). Similar problems exist for symptom checklists used to identify psychopathology across cultures. Researchers have found higher levels of psychological symptoms among Puerto Ricans than other North American populations for over 20 years (e.g., Srole et al. 1962; Dohrenwend and Dohrenwend 1969); however, the issue is still unresolved whether levels of psychiatric illness are higher among Puerto Ricans or whether this represents culturally-prescribed differences in ways of communicating symptoms. Haberman (1976), for example, found that symptom scores on the 22-item screening instrument used in the Midtown Manhattan Study were higher for Puerto Ricans living on the island than for those living for a long period in New York, indicating these rates represent "culturally patterned differences in modes of expressing distress" rather than level of psychopathology. In addition, symptom levels seem to have quite different relationships to impairment levels across cultures. For example, in the Sterling County and Yoruba studies, the Yoruba were found to have far higher levels of symptoms (particularly of somatic symptoms) than Canadians but far lower rates of significant social impairment (see Murphy 1982, p. 53 for a discussion).

Diagnostic instruments such as the DIS were designed in part to overcome difficulties in determining norms and cutoff points. However, the problem of the indeterminacy of norms is embedded in the instrument as it is in diagnostic work. How serious should heart palpitations or loss of energy be before a person is considered to have met criteria for these symptoms? Given enormous cultural differences in care-seeking patterns (e.g., Lin et al. 1978), can the fact that an individual has or has not sought help for a particular symptom be used to determine whether the individual has met a particular symptom criterion [as is the case for both the DIS and the Schedule for Affective Disorders and Schizophrenia (SADS)]?

Clearly, one of the identifying features of culturally competent clinicians is that they are able to make a reasonable determination of whether a particular behavior or experience is culturally normal or is a symptom of pathology. However, cultural judgements about normalcy often masquerade in diagnostic manuals and epidemiological instruments as scientific objectivity.

The Problem of Centricultural Bias. Wober (1969) has labeled those research strategies that begin with a research instrument developed exclusively in one culture and directly translate them into languages for use in other cultures as "centricultural." Difficulties associated with the centricultural approach are common to diagnostic work and research.

Anthropological and cross-cultural psychiatric research has found great variation in the content of symptoms across cultures. For example, the Yoruba literature (Murphy 1982) indicates that anxiety disorders are associated with three primary clusters of symptoms: worries about fertility, dreams of being bewitched, and bodily complaints (Collis 1966, Jegede 1978). Research by an Ibo psychologist indicates that a rich somatic vocabulary is typical of Nigerian psychiatric patients (Ebigbo 1982). For example, patients commonly complain that "things like ants keep on creeping in various parts of my brain," or "it seems as if pepper were put into my head," in a fashion that would be interpreted in nearly any American patient as delusional. Chinese patients commonly present with a variety of somatic and somatopsychic complaints, including such culture-specific symptoms as heaviness or pressure depressing into the head or chest, fear of excessive loss of semen with diminished vital energy, excess of hot inner energy, and fear of cold in the body (Kleinman 1982). Iranians often complain that their hearts are upset (Good 1977).

In addition to these clinical and anthropological reports, factor analytic studies have found distinct variations in symptom clusters associated with particular psychiatric disorders. For example, Binitie (1975) found that while depressed patients in England exhibited most of the typical symptoms that serve as DSM-III criteria for affective disorder, many of the symptoms were absent or rare in depressed Nigerians. They rarely contemplate suicide, and they are more apt to complain of somatic symptoms and delusions of persecution or neglect self-care. British patients more commonly express guilt, self-reproach and suicidal thoughts.

Culture-specific idioms of distress and symptom vocabularies are not merely typical of exotic or non-Western cultures; they are the language in which members of any culture express distress. Complaints of feeling stress or pressure, of feeling sinful and deserving God's punishment, are cultural idioms. Complaints of nervios and ataques seem common among some Hispanic cultures (e.g., Abad and Boyce 1979, Low 1981). Somatic idioms are certainly more prevalent among Puerto Ricans and blacks than among Anglos (Abad and Boyce 1979, Carter 1974) and may have quite different diagnostic implications among different groups.

Two very clear difficulties arise from the centricultural approach to translating diagnostic criteria and epidemiological instruments. First, a wide range of symptoms typical of a particular culture may simply be omitted from consideration because they are not present for the development of the criteria. Morbid concerns about fertility or dreams of being bewitched simply do not appear as criteria in the DSM-III and thus would not appear in a Nigerian manual, despite their importance (see Orley and Wing 1979 for such an example). Imagine reversing the process: if Ebigbo's Psychiatric Screening Form were translated from Ibo into American English, how would those somatic symptoms mentioned above be translated? What typical American symptoms with significance for differential diagnosis would simply be eliminated from consideration?

Second, it seems likely that there are differences in content and duration of symptoms of diagnostic significance across cultures. Simple translation of those symptoms found to result in valid diagnosis among particular American populations does not ensure the validity of these symptoms as criteria among other cultures.

The extent to which these difficulties raise problems for diagnosis among various American ethnic groups is not yet clear. There are certainly indications that the centricultural bias raises problems of validity not only for cross-cultural work but for diagnosis among some American populations as well. Manson et al. (1985) indicate that the 30-day duration criterion for major affective disorder is inappropriate for the Hopi. Canino et al. (1985) report that 67 percent of the items found on the DIS developed for Mexican Americans required some changes, raising the question of whether a deeper problem is being reflected.

The Problem of Indeterminacy of Meaning. The major method of translation of psychiatric criteria is designed to find "semantic equivalents." Items are translated, back translated, and administered to bilingual subjects. Such a method assumes the existence of objective and universal referents, which may be represented by different symbolic forms in different cultures. For a term like "headache," this may be true. In general, however, the referents of symbols--i.e., their meanings--are aspects of a culture or a life world, not objects outside of language through which language obtains meaning (see Good 1977, Good and Good 1982 for elaboration). "Heart discomfort" for Iranians is not the equivalent of "heart palpitations" for Americans; it does not mean the same thing (Good 1977). It is a symbol that condenses a distinctive set of meanings, a culture-specific "semantic network," for Iranians. Complaints of feeling impure in India refer to a semantic domain of profound cultural significance, one that regulates caste, sexuality, and social hierarchy; there simply is no equivalent among Americans. Feelings of guilt and sinfulness are rooted in Christian culture. When Orley and Wing (1979) translated the PSE question for "pathological guilt" into Luganda (in research in Uganda), they used the question "Do you sometimes blame yourself for something that was a mistake?" Is it any wonder they found unexpectedly high levels of guilt associated with depression, or that there has been such debate over whether guilt is associated with depression for Africans?

We do not question that translation of criteria should include those domains that appear to have biological significance, for example the vegetative signs associated with neuroendocrine functioning for the depressed. However, anthropological techniques are available for identifying the semantic domains associated with a particular illness in the discourse of patients. (See Kinzie et al. 1982 for an example of development of a Vietnamese depression scale beginning with such an approach.) For example, such domains for depressed Iranians include "grief and sadness" (gam o gosseh), "anger" (asabani), "sensitivity" (hassasiyat), and "mistrust" (see Good et al. 1985). These refer to culture-specific forms of social life and personal distress for Iranians. Not only are they of diagnostic significance, they are complaints that open onto a culture-specific world of suffering for the culturally competent clinician.

The Problem of Narrative Context. Put simply, people of any culture express symptoms differently in different contexts. This may have unrecognized significance for the determination of diagnostic criteria. Chinese have long been believed to "somatize" depression (Tseng 1975, Kleinman 1977). Cheung (1982, 1984), in research in Hong Kong, found that outside of medical settings Chinese report experiencing a high level of psychological symptoms. However, they prefer to discuss these with friends and to discuss somatic symptoms with physicians. It seems likely that an important part of what has been seen as the Chinese tendency to somatize is a characteristic of the communicative context in which research was undertaken, rather than primarily of the range of feelings or experiences typical of Chinese.

Our review of the work on misdiagnosis among American minority groups made it clear that important aspects of clinical presentation of ethnic patients with Anglo clinicians result from norms for communication within the clinical context; a sampling of the same patient's complaints in other contexts--at home, with primary care practitioners, with native healers, in a church healing ritual--might well give a very different picture of the patient's symptoms. Symptom criteria for diagnosis might thus vary by narrative context.

The Problem of Category Validity. We have been arguing that cultural meanings and norms for expressing distress significantly alter the relationship between symptoms and diagnostic entity, posing serious problems for translation of diagnostic criteria and symptom-based epidemiological instruments. Ultimately, however, one must ask whether psychiatric diagnostic entities are universal categories--whether diagnostic categories primarily reflect medical culture (and therefore change with changes in medical theories), whether they characterize certain American and European populations (and therefore are only valid within those populations), or whether they are universal psychobiological and/or psychological entities. We have little doubt that schizophrenia and some forms of depression and anxiety can be found in all populations. However, whether depressive illnesses experienced primarily in psychological terms and associated with strong feelings of remorse and guilt should be equated with that experienced primarily in sociosomatic terms is open to question (see Kleinman and Good 1985 for extended discussion of this issue; cf. Marsella 1979). It may be that those affective disorders defined by DSM-III are cultural variants of an underlying depressive disorder, expressed in significantly different ways in some cultures. The same is certainly true for anxiety disorders (see Good and Kleinman 1985b) and for even more vaguely defined "somatoform disorders." Thus the problem may lie at a deeper level than simply mapping the correct symptoms for each culture onto universal categories. Only research that is open to this issue can tell us whether particular categories are universal or whether seeming universality is produced as an artifact of research and clinical method.

Anthropology, Diagnosis, and Ethnicity

A meaning-centered or interpretive anthropology challenges psychiatric researchers and clinicians on two grounds. First, it challenges the assumption that symptoms are reflections of psychobiological phenomena and that their primary meaning resides in those biological phenomena to which they stand as signs. Instead, it argues for a recognition that "symptoms" are medical abstractions from culture-specific forms of discourse, that is from persons' narrative accounts of their own suffering or that of somone in their primary social network. Their meanings reside not only in disordered biology, though biology certainly constrains and in some cases actively constructs experience; the meanings of symptoms also are grounded in and open onto life worlds that are as distinctive as the cultures of our universe. Second, anthropology thus challenges the centriculturalist view of interpretation of diagnostic criteria. It suggests that interpretation should follow after inductive studies of psychopathology within cultures provide grounds for real comparisons of quite distinctive discourses of distress, rather than simply beginning with criteria found valid within particular American populations and assuming that finding "semantic equivalents" of diagnostic criteria will define a population suffering from the same universal disease.

We recognize that we are here defining ethnic groups as distinctive cultures or subcultures and that there are difficulties with this definition. However, while analysis of social factors producing psychopathology and inequities in access to services requires a primarily social view of ethnicity, we believe that issues of cultural meanings come to the fore in discussing competence for diagnosis and psychotherapy.

The anthropological perspective developed here provides an approach to analyzing culturally competent diagnosis--in terms of various dimensions of translation between diagnostic criteria and culture and context-specific discourses of patients--and points to a similar analysis of culture and psychotherapy.

THE CULTURAL CONTEXT OF PSYCHOTHERAPY

We will simply outline several issues for understanding cultural competency in psychotherapy that follow from the kind of analysis developed in the preceding sections. Our work in a "cultural consultation clinic" in a university department of psychiatry in California (see Good et al. 1982, 1985) suggested to us that symbolic and interpretive processes play a central role in (1) the establishment of intimate therapeutic relations; (2) the control of "affective distance" in therapy; (3) the development of metaphors critical to healing; and (4) issues of reflexivity and countertransference that emerge in therapy. These provide grounds for defining culturally competent psychotherapy.

First, the definition and establishment of intimate relations varies enormously across cultures. We find that members of one culture often complain that those from another are "shallow," that their family relations, their rituals, their friendships lack depth and feeling. They complain that it is difficult to feel close to persons from another society, that persons from that society are distant or intrusive. These qualities are often seen as characteristic of that culture rather than as problems in intercultural interpretation and communication. A central quality of a therapist is that he or she is able to establish intimate relations with patients and manage levels of intimacy as the therapeutic relationship develops. We believe that culturally based difficulties in establishing intimacy lie at the root of common claims that members of particular cultural groups are not appropriate candidates for psychotherapy.

Second, a critical feature of competent psychotherapy is the ability to manage "affective distance." Scheff (1977) argues that individuals may be emotional "underdistanced" or "overdistanced"; for example, a person may be totally and hopelessly overcome with grief or, on the other hand, unable to experience a grief that still has power for that person. A person may be in a violent rage or completely out of touch with anger. A central function of both ritual and psychotherapy is management of emotional distance so that the affect can be safely experienced and discharged or integrated (see Kapferer 1979 for an example). Again, management of affective distance is a culturally fraught process. Particular symbols have not only unique personal significance but affective meanings that are as much a feature of the cultural landscape as family relations and cultural values. Manipulation of these symbols in psychotherapy thus has quite different effects depending on the "semantic networks" (Good 1977) in which they are embedded. We found in our cultural consultation clinic that the spiritualist healers with whom we worked could very quickly recognize issues having emotional potency for the patient, use ritual means for inducing relaxation, then help the patient to experience with directness overdistanced emotions. We believe the ability to manage emotional distance therapeutically is a central feature of cultural competence.

Third, much of the work of healing is done through the development of culturally powerful metaphors. Lakoff and Johnson (1980) argue that much of our phenomenal world is metaphorically constructed, and that the central metaphors vary greatly by society. Traditional healing systems draw on metaphors resonant within the culture to construct the illness reality and then symbolically manipulate it to effect healing. A central image, such as a spirit, will be constructed in a ritual setting; the sick person will be encouraged to identify the image as the source of the illness, thereby associating personal meanings with a public ritual symbol; and therapy will be directed at removing or transforming the illness reality constituted in this ritual (clinical) process. (See Lienhardt 1961 for a classic account in anthropology.)

Much psychotherapy proceeds along a similar course--sometimes consciously, as the therapist likens the patient's condition to a culturally syntonic image, sometimes without explicit awareness, as patient and therapist share metaphors as part of their assumptive world. Therapy may also fail because the patient's metaphoric understanding of the illness condition is hidden from or rejected by the therapist, or because the therapist is unable to construct a metaphor with adequate power to provide the patient leverage to transform the grounds of suffering. One of the hallmarks of the culturally competent psychotherapist is the ability to recognize the metaphors that have power within the patient's discourse or to construct powerful metaphors, then to work through the patient's problems through the symbolic transformation of the metaphor.

Finally, as we have discussed above, the transferential relationship always has an "ethnic" component when therapeutic encounters take place across cultures or subcultures. The culturally competent psychotherapist should be able to recognize and manage this dimension for the good of the patient.

CONCLUSION: TWO PROPOSALS FOR TRAINING AND RESEARCH RELEVANT TO CULTURAL COMPETENCE IN DIAGNOSIS AND THERAPY

In conclusion, we offer two suggestions we believe may contribute both to research and programs of training relevant to the issues we have been discussing. We believe it is critical that training for cultural competence be combined with research. As indicated by the body of this paper, we simply do not have the data to indicate precisely how psychopathology and appropriate techniques for psychotherapy vary across American subcultures; even if we did, so important is relationship and context to the work of assessment and therapy that such knowledge could not be learned simply as a set of criteria or techniques. Our suggestions thus deal with approaches to assessment and psychotherapy processes, rather than simply content.

First, we propose the development of "cultural consultation clinics" as sites for research and training relevant to cultural issues in assessment and therapy. In our previous experience (Good et al. 1982, 1985), a cultural consultation clinic was developed as part of a behavioral medicine clinic associated with a psychiatric consultation-liaison program. In our current experience at Harvard, one of our postdoctoral training fellows (in a program in clinically relevant medical anthropology) is working with hospital clinicians to develop a clinic to specialize in assessment and treatment of Hispanics. In other contexts, such a clinic might be multiethnic, that is, a clinic with a variety of cultural specialists available to make culturally relevant assessments and therapy recommendations or to provide specialized treatment.

A cultural consultation clinic should have integrated clinical, teaching, and research functions. As a clinical facility, it can provide assessments (either within its own setting or in another hospital or clinic setting) of the cultural issues involved in diagnosis and treatment of patients, where these have come to be a problem. Diagnostic issues (e.g., Is a particular behavior normal within the patient's culture? What are the meanings associated with a particular complaint?) and treatment questions (e.g., How can a more intimate therapeutic relationship be negotiated? What are the critical affective issues that need to be addressed?) such as those discussed in the body of this paper are appropriate issues for consultation. Such a clinic might also provide culturally appropriate therapies in some cases.

As a teaching site, such a clinic can serve to clarify the role of cultural issues for trainees. Trainees can work alongside cultural specialists, either clinicians or community persons, to learn awareness of their own cultural countertransference, to learn to deal openly and explicitly with the culture-specific meanings associated with symptoms and therapies (for example, to learn to elicit explanatory models and patients' metaphors), and to try approaches to therapy not taught as regular modalities.

A cultural consultation clinic can serve as a site for research into the kinds of issues raised in this paper. We focused here on diagnositc issues because we believe they are particularly urgent. While it is encouraging that the DIS is being adapted for use with great care, we believe this approach should be combined with research into central issues, such as investigation of culture-specific symptoms and illness idioms, research into semantic networks and semantic domains to which symptoms and elements in patients' discourse belong, the effect of clinical context on presentation of symptoms, culture-specific cognitive schemata associated with particular illnesses.

Our second recommendation points to one specific mode of combining research and assessment. We propose that a cultural axis be developed as a research axis to be added to the psychiatric diagnostic and statistical manual, and that social and cross-cultural psychiatrists, anthropologists, psychologists, and other social science researchers be challenged to demonstrate the utility of such an approach in their research (cf. Good and Kleinman, 1985a). The axial structure of DSM-III represents a compromise among competing and complementary views of psychiatric disorders. It construes psychopathology as a heterogenous psychiatric disease entity (axis I), as a pathology embedded in a particular personality (axis II), as a response to stressful social precursors (axis IV), and as a level of social dysfunction (axis V). These represent current ways in which clinicians evaluate the nature and extent of psychopathology, each from the perspective of the clinician. However, none of these axes represent evaluation of the patient's condition from the patient's own perspective or that of the patient's family or primary social group. The cultural axis we propose would represent this perspective, what anthropologists have called the "emic" perspective or that from "the native point of view" (Geertz 1983, pp. 55-70).

There is a strong evidence to suggest that the cultural meaning of a disorder, the idiom in which the disorder is experienced and communicated, and the social evaluation of the disorder by members of the sufferer's primary social network have an important influence on the illness as a social reality and thereby on the course of the disorder and its effect on the social functioning of the sufferer. In some cases such evaluation may have more significance than the axis I diagnosis. Researchers should specify the sources of data, the categories of data to be gathered, and the means of recording the data (categorical, descriptive, or linear). We suggest that researchers and clinicians should record the culture-specific illness category, the explanatory model, the illness idiom, the predominant care-seeking pattern, and the perceived level of disability. For example, an axis VI assessment might record that a juvenile Puerto Rican patient's family interprets the disorder as an ataque de nervios, that they believe began with the patient's learning suddenly of the death of a friend, that they believe the disorder seriously affects the patient's ability to function in public and work settings, but that they believe the the disorder is acute and likely to pass as the patient resolves his grief and matures as an adult. Such information would add significantly to a diagnostic assessment that recorded generalized anxiety disorder, dysthymic disorder, and undiagnosed epileptiform seizures. Perhaps more to the point, an axis VI assessment that a major depression is interpreted by one patient and his or her family in somatic terms (as neurasthenia, as undiagnosed medical illness) and by another in a religious idiom (as punishment of God for sins) may turn out to have greater implications for prognosis and treatment than the diagnosis major depression alone. Establishment of a cultural axis would promote systematic investigation of the nature of culture-specific evaluations of psychiatric disorders and of their effects on phenomenology, prognosis, and appropriate treatment. Employed in training, it would encourage clinicians to systematically review cultural aspects of patient care often neglected. We believe it would both promote cultural competence and serve to focus research on what constitutes culturally competent assessment and therapy.

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CHAPTER 2

CROSS-CULTURAL COMPETENCE IN MINORITY COMMUNITIES: A CURRICULUM IMPLEMENTATION STRATEGY

Ramon Valle, Ph.D.

INTRODUCTION

Cross-cultural competence can best be conceptualized as the ability of the mental health practitioner or researcher to demonstrate a working understanding of (1) the symbolic/linguistic systems, (2) the naturalistic-interactional patterns, and (3) the values and beliefs held by a target ethnic minority population and the ability to incorporate these elements into any planned intervention with members of the ethnic group. Despite a multitude of culturally oriented curriculum initiatives, forums, and reports extending well back to the late 1960s, content supportive to the development of cross-cultural competency has not been institutionalized within the curricula of the several mental health disciplines (Chunn et al. 1983, Rogler 1983).

A number of barriers can be identified as contributing to this circumstance. First and foremost, we lack an appropriate teaching paradigm for approaching cross-cultural clinical and research practice. Second, the pool of relevant information for use in the curricula of the core mental health disciplines remains uneven. Unfortunately, in many instances our knowledge about minority groups is not of generalizable quality. Third, we have not formed an adequate strategy to deal with the "politics of knowledge" that always accompanies curriculum development. In this context, we lack an appropriate strategy for "diffusion of innovation." This factor, combined with inertia on the part of individual practitioners and researchers at all levels of the mental health establishment, forms the fourth barrier.

While the barriers are formidable, they are not insurmountable. A curriculum change strategy, focusing on the development of cross-cultural competency within mental health, is attainable. A prerequisite is careful planning, incorporating the following elements. First, there is a pragmatic need for agreement on a cross-cultural curriculm paradigm for the field of mental health. Second, there is an accompanying need for agreement on the key content for use in the core curricula of the mental health professions, recognizing that a broad-scale breakthrough in cross-cultural knowledge may be some years away. Third, we need to move toward what Rogers and Shoemaker (1971) term as effective programs of planned change or innovation. Unfortunately, with regard to ethnic minority content in mental health, we have proceeded in what Rothman et al. (1977) identify as a "spontaneous" rather than a "planned" change approach. In a spontaneous mode, we bring forward some knowledge relevant to the target populations and then hope that that cross-cultural competencies will emerge as serendipitous outcomes of the effort. In a planned effort, we incorporate the following elements: (a) key selected innovations; (b) key "early adoptors" of these innovations who will be "publicly" recognized for their efforts; (c) the concurrent active involvement of "recognized" curriculum "decisonmakers" who will "sanction" the proposed innovations; and (d) the careful selection of target teaching systems within the field of mental health whose participants will work to implement and regularize the innovation.

The issue at hand, therefore, is to agree on the constituent elements of a model for cross-cultural competence in mental health and then to implement cross-cultural training for the several core disciplines within the field. This paper will delineate a suggested approach.

WORKING DEFINITIONS

As used here, cross-cultural competence is defined as the ability of the mental health professional to demonstrate the following: (1) a working knowledge of the symbolic/linguistic, "communicational" patterns of the target ethnic minority group(s); (2) knowledge and skill in relating to the naturalistic/interactional processes of the target population; and (3) a grasp of the underlying attitude, value, and belief systems of the target population.

The concept of "minority" used herein applies to the four ethnic groups of color within the United States (Lum 1986). It is true that the term can have several meanings. For instance it can be used to designate "gender" minorities. While women may outnumber men, comprising more than half of the United States' general population, their minority status becomes readily evident if one compares their salaries to those of men in the same job category. It is also evident if one analyzes the role of women with regard to positions of power and influence within the society. Women are very much in the minority.

The term can also be applied to groups set apart by their lifestyles. In this context homosexuals certainly fit the designation of a minority group within the larger society. This notion of "minority" can also be extended to certain "categorically" designated groups, such as the elderly, youth, the poor, and the handicapped. Within this paper, however, the terms minority or ethnic minority will be applied only to the four sociocultural groups of color in the United States, namely American Indian/ Native Americans, Asian Americans, Blacks and Hispanics. Other issues, such as gender, lifestyle, and socioeconomic and underclass status, will be discussed as applicable within the focus of this analysis. It is important not to equate poverty and culture (Valentine 1979). Unfortunately, much of the literature available in the ethnic minority arena is replete with this problem (Valle 1979, Bacarisse and Salcido 1983, Valle 1985).

In this context, the definition of "culture," proposed some time ago by Kluckhohn (1962), maintains its currency for the present discussion.

> Culture consists of patterns, explicit and implicit, of and for behavior acquired and transmitted by symbols consisting of the distinctive achievement of human groups, including their artifacts; the essential core of culture consists of traditional (i.e., historically derived and selected) ideas and especially their attached values; culture systems may, on one hand be considered as products of action, and on the other hand, as conditioning influences upon future action (p. 73).

An important feature of the Kluckhohn construct is that cultures can be viewed as dynamically reshaping themselves over time, responding to the changing demands of environmental circumstances, not the least of which is the proximate interactive influence between different social groups. This perspective is particularly applicable wherever cultures interface with each other, as do ethnic minority groups and the majority society in the United States. It is true that often the interface is consciously attempted from only one direction. This is to say that for purposes of group survival, U.S. ethnic minority groups seek some form of interaction, even if this interaction is not reciprocated by the majority group members. Regardless of intent, though, the interface dynamic is there and can be examined in terms of degrees of acculturation.

It is not the intergroup behavorial arena alone that can furnish examples of the dynamic and adaptive nature of cultural patterns. Careful sociohistorical examination of the normative perspectives of the different generational cohorts within a single ethnic minority group can illustrate the point. The Japanese-American community offers an excellent example of such intragroup difference and adaptation.

A variety of subtle, but very real differences in world view orientations can be noted between pre-World War II Japanese-American *issei* (the Japanese term for first-generation arrivals to the United States) and the post-World II *issei*. Both speak the same language and both revere the ancient traditions of their homeland culture. The careful observer, though, can detect differences between the subgroups, particularly when members of each are referencing their historical/generational experiences. The former came from a more traditional Japan and underwent a traumatic incarceration/internment experience during World War II. This "new" *issei* subgroup is coming from a very changed, post-industrial, technology-dominated Japan, and has sociocultural referents outside the experience of the "old" issei.

Acculturation dynamics and intragroup cultural change can also be seen among Hispanics working along the United States/Mexico border. For instance, the language of this segment of the Hispanic population contains a mixture of what are called "pochismos" (American terms that have been cast, without translation, into the Spanish idiom) which facilitate intergroup communication between Mexican nationals and Mexican-Americans in the border region but which are frowned upon by Mexicans from the interior.

Attention to intercultural exchange is not to take away from the maintenance of ethnic distinctiveness, as exemplified by American Indians who have retained their cultural identity, preserving their tribal languages and customs despite more than 400 years of oppression. Perhaps this ethnic minority group can serve as a "cultural marker" to assist mental health professionals to understand the persistence of cultural identity over time, as outlined by Spicer (1971), despite extremely destructive acculturative pressures.

In brief, cultural identity persists among ethnic minority populations in the United States. There is no question that changes and adaptations take place, but the core of that cultural identity remains. The ability of the mental health clinician and researcher to tap into this core constitutes cross-cultural competency.

THE COMPONENTS OF CROSS-CULTURAL COMPETENCY

As noted above, there are three principal components of cross-cultural competency wherein the mental health professional can access another culture: (1) the symbolic/linguistic, (2) the interactional, and (3) the value and belief systems of the group (Spicer 1971). Collectively they constitute the "bread and butter" skills employed by the mental health clinician and researcher for *accessing any population* as well as for *maintaining* either a therapeutic or research intervention relationship with a respondent. The proficient mental health professional, at any level of intervention, aims at using the language and attendant nonverbal symbolic communication patterns of the subjects or patients for establishing relational linkages with them, as well as for deciphering their underlying attitudes and value orientations. Within the cross-cultural intervention context, the mainstream mental health clinician and researcher must be sufficiently grounded in the day-to-day meanings of the ethnic minority group members' symbolic, interactional, and normative belief system to have the intervention take hold from a cross-cultural perpective.

Language and Symbols

Included under the rubric of cultural symbols are not just the written and spoken language but also the "artifacts" and traditional cultural identity symbols with which individuals surround themselves. These include the ethnic group's heros, folk art, ceremonies, and celebrations. Many an alert professional has made viable cross-cultural contact by participating in the celebrations of a community in order to demonstrate an appreciative understanding of the ethnic group's unique culture.

Many ethnic minority cultures in the United States still retain their language of origin with English as a second language. These original languages offer many clues to mutual relationships and group values. Many of the languages contain a number of different modes of address that can tell the culturally aware observer about differences in status between individuals and the closeness or social distance between them. Strangers and intimates can in certain instances be identified by speech patterns. Moreover, through both written and spoken language, one can gain considerable understanding about the individual's ways of coping, about ways of accepting help, and the group's mutual assistance styles. For example, in Spanish one does not so much announce that one is here to help, but rather uses language that asks for "permission" to be of help.

Subtle as these nuances may appear, they are often the key to the mental health professional's success or failure in making contact with ethnic minority individuals as well as in gauging the individual's openness to proferred services or to participation in a research effort. At the same time, a real problem facing the professional must be recognized. It is not uncommon to find multiple languages in use within specific minority groups. For example, among Filipinos, there are a number of dialects in addition to Tagolog and Ilucano. Among the Chinese, while the written language remains essentially the same, there are the Mandarin and Cantonese dialects to name but the two principal language groupings. Even Spanish, which is nearly universal throughout Central and South America, has its regional variations. Therefore, even though Mexican Americans, Puerto Ricans, and Cubans can generally understand each other, there are enough variations in accent and work usage between groups to make even the fluent Spanish speaker pause. To complicate the picture further, a large portion of Latin America is not Spanish speaking. Brazilians speak Portuguese; Haitians, a Caribbean area people, have French as a core element of their language.

Not all mental health professionals will or can become bilingual, let alone multilingual. But the problems surrounding the growing multilinguality of the social environment are not an excuse for failing to become bicultural. Biculturality is within everyone's grasp. As of this writing, one can find any number majority-culture clinicians and researchers who are able to communicate their intent across cultures without having command of the language of the target ethnic minority group. In such situations, it is usually necessary to extend the "community contact" process further than previously considered.

Admittedly the difficulties attendant on biculturality can become quite pronounced when multiple language capabilities are required. It is here that the translation/back translation strategy noted in the literature can help the professional to gain a basic understanding of the communicational nuances of the ethnic group (Brislin 1973, 1980; Triandis 1976; Aday et al. 1980). In the instance where the clinician and/or researcher is not familiar with the group's language of origin, these nuances are available through the translation/back translation route of research instruments and clinical forms. In addition to translaters there are any number of ways to locate and involve local experts, "cultural guides," or brokers who, as key informants, can assist the mental health agency and the reseacher to gain a working insight into specific ethnic groups (Green 1982). For example, many human service agencies, university and local libraries, as well as a number of State and Federal departments offer a variety of media to assist the outsider to become familier with a specific ethnic group.

Interactional Patterns

Primary group/natural social network interactional patterns are a second rich avenue for obtaining culturally relevant data for clinical and/or research interventions. The mental health and related literature is replete with discussions of natural social network processes relevant to a great variety of populations, including ethnic minority groups. Three different primary group/natural network formats can be distinguished: the family, the peer and/or community group, and what has been described in the literature as the linkperson or natural helper social network mode (Valle and Martinez 1981).

The three natural social network modalities each have distinguishing organizational features that affect the professional in establishing contact and obtaining entry to the ethnic culture. The family obviously requires some form of consanquineal and/or adoptive status for membership and the naturally accruing rights and obligations of members. The aggregate, peer, or community group also requires membership status but is available to nonkin individuals who agree to adhere to the group's goals and who meet the group's criteria for admission and ongoing participation. The linkperson mode is somewhat more subtly present in the social environment; it is composed of dyads and triads (as well as multiples of these primary relationships) linked by ties of mutuality. These ties extend from friends and neighbors all the way through to natural helpers who can be often located in the community through ordinary, but focused, methods of mental health outreach. Among Hispanics, these helpers have been identified as servidores (Valle and Mendoza 1978, Vega et al. forthcoming). They are discussed more extensively below.

The family tends to be the most easily recognized natural social network format. In fact, much mental health intervention at the clinical and research level centers around ignoring the other two primary group formats. The need in cross-cultural practice is to go beyond the family and to understand the configuration of the ethnic group's peer associations and friendship dyads (or multiple dyads) as part of the individual's primary group configuration as initially conceptualized by Cooley (1909).

Group Norms, Values and Beliefs

A third major area for the development of cross-cultural competency in mental health is that of understanding and assessing the normative/value-belief systems of the various ethnic minority groups. For example, many Asian American peoples share values and world views stemming from Confucianism, Laoism, Taoism, and Buddhism (Ishisaka and Takagi 1983). This is not to say that values are identical among subgroups, but rather that community-held value patterns can be discerned by the culturally aware practitioner. It is here that the professional working with Asian-Americans learns to recognize the concept of "burden" as it affects the mental health service and/or research exchange. In practical cross-cultural terms, this means that the Asian-American recipient of the service and/or research intervention may not interpret the professional's proposed action in positive terms. The prospective recipient may instead view the intervention as a "burden to be incurred" that will need to be reciprocated at some point in the future (Ishizuka 1978). This may well explain reluctance among some Asian-Americans to use services and/or participate in studies that might meet their needs.

For the Hispanic, though, the same behavioral reluctance to participate in a study and/or use services may be traceable to a quite different belief or value dynamic, namely, the relatively fierce desire for personal independence, best expressed through the term orgullo (cultural as well as personal pride) (Queseda 1976, Levine and Padilla 1980). While the net effect of both the Asian-American and the Hispanic behaviors is nonuse of services or nonparticipation in research efforts, such refusal really stems from different cultural orientations. They require differential understandings on the part of the professional in order to counterbalance the possible negative impact of the intervention and to assist in overcoming recipient's reluctance. In the case of the Asian-American, the professional might have to steer intervention toward allowing for appropriate "gift" reciprocity exchanges. In the case of the Hispanic, the professional would need to be alert not to damage the potential participant's feelings of self-worth or to create a sense of dependency. While such clarifications require further empirical validation, they do point to the importance of the subtle nuances underlying apparently similar behaviors.

A WORKING MODEL

From the mental health perspective, the competencies presented above are incomplete if they are not linked to the actual behaviors of the members of ethnic minority groups in the context of their social environments. This poses difficulties for the clinician and researcher alike, particularly, if as Kluckhohn (1962) observes, cultures are dynamic, always in movement, taking their members with them as changes occur over time. The potential difficulties in applying the framework discussed to this point can be resolved if cultural dynamics are understood as taking place along an acculturation continuum.

In this context, all the U.S. ethnic minority groups--and for that matter all the world's peoples--are in some way experiencing acculturative forces. However "traditional" Japanese-Americans may appear, as indicated above, there is a considerable difference between pre-World-War-II Japan and the Japan that is now in the forefront of the computer revolution. The central African tribal farmer with a transistor radio strapped to the plow is not exempt from these influences. It should be noted that those acculturative pressures are all the more intense for ethnic minority groups in the United States.

It is perhaps best, then, if the members of these groups are seen as a continuum from "least" to "most" acculturated to the mainstream U.S. society. Moreover, this acculturation may take place differentially within any of several domains--the home, the neighborhood, the workplace, etc. Hispanics, particularly those of Mexican heritage, can serve as a case in point. Historically, the members of this group have been--and continue to be--affected by a variety of sociopolitical, economic and macrocultural forces. Moreover, the Mexican people themselves are a mix of varied genetic and cultural influences, ranging from the Indian to the northern European (Vasconcelos 1925). Romano (1969) has traced the outlines of this sociocultural, socioeconomic, and sociohistorical evolution and posited a typology that encompasses the Mexican-American group as a whole.

- Realigned Pluralism: Persons with traditional/culture and homeland of origin beliefs and practices and who have developed parallel activities and organizations but who have maintained them as separate and barrio-oriented entities.

- Biculturalism: Persons who reintegrate their cultural past at the lifestyle and the language/group interaction/group values identification level but also represent a fusion of cultures though not at the expense of the other.

- Stabilized Differences: Persons of Mexican heritage who have maintained basic Mexican cultural ways as byproducts but don't identify with the core issues of the culture, e.g., the "Californios."

- Anglo Saxon Conformity: Persons of Mexican heritage who have given up all identity with their cultural past.

For our purposes, this formulation can be recast into a three-point continuum collapsing the "stabilized differences" and "Anglo Saxon conformity" designations into an "assimilated" category.

Table 2-1 summarizes the reconfigured continuum for use in the field of mental health.

Table 2-1: The acculturation continuum

Traditional	Bicultural	Assimilated
Individuals remain locked in their traditional cultural systems and normative expectations in most, if not all domains.	Individuals relate to both their own culture of origin and to the mainstream cultural ambience without conflict relative to functioning in different domains.	Individuals have passed into the mainstream culture in all or most domains.

Domain-Specific Acculturation

From a mental health standpoint, we must also recognize not only that acculturation manifests itself unevenly along a continuum but that it can also express itself unevenly within different domains. Moreover, we must distinguish between the socioeconomic and the sociopolitical status of the group within society. The concept of domains used here follows Pearlin and Schooler (1978) i.e., interaction and coping strategies employed in the workplace, the home, and in the context of the marriage/partner relationship, as well as with regard to help-seeking and help-accepting health and mental health behaviors. Equally important is the individual's acculturative performance within what Bandura (1982) terms the group and personal power domains. The problem here for the mental health researcher and practitioner is the misattribution of cultural attitudes, beliefs, and practices to domain-specific behaviors. In other words, there is a risk of confusing socioeconomic and social status dynamics with sociocultural phenomena.

Some brief examples will illustrate the point. The most graphic are the nutrition programs initiated by the Federal Government in the 1970s. These programs, designed to meet basic nutritional needs of the elderly, completely ignored the dietary/culinary variants between members of the majority culture and ethnic minority potential consumers. The providers could not understand why the elderly members of minority groups, though in greater need than their Euro-Anglo counterparts, did not participate in the nutrition program. The complexity of cultural customs, culinary traditions and expectations, including an interactional ambience where one's own language might be spoken, had been forgotten. If we think about all the factors surrounding and affecting the apparently simple act of eating, how much more complex are the cultural aspects of health and mental health interventions?

The use of a cross-cultural diagnostic/assessment and intervention "filter," such as suggested in Table 2-1, would have indicated early on to the professionals that many of the elderly were acting from a more traditional rather than an assimilated or bicultural orientation. It was not until much later, after much grief on the part of providers and ethnic minority advocates alike, that culturally appropriate changes were initiated. A previously acquired "cross-cultural mind set" would have immediately assisted those involved to recognize basic differences in culinary traditions. As it was, the providers were operating from a viewpoint of socioeconomic needs and ignoring the cultural diversity component. A cross-cultural interventive paradigm would have indicated that even though wheat is a basic staple food of many cultures, the person of Jewish background may mold it into a matzo, the Hispanic into a tortilla, and the Euro-Anglo into a slice of bread--each approach representing a historically evolved cultural approach to a specific group process with an extensive set of attendant customs and expectations.

Closer to the field of mental health is the problem facing researchers developing questionnaires and clinicians developing screening and intake instruments. The issue of confounding socioeconomic variables (including income level, social class, and formal education status) with cultural dynamics immediately comes to a head in this arena of professional practice. The various screens used to assess cognitive function can serve as a case in point. As reported in the Los Angeles Epidemiological Catchment Area Study, a number of items on the Mini Mental Status Examination are confounded relative to ethnicity and socioeconomic status (Escobar et al. 1985). Socioeconomic status factors must be sorted from culturally derived behaviors. As Valentine (1979) has warned, poverty and culture are not synonymous. With these considerations in mind figure 2-1 summarizes the discussion to this point. The suggested design can serve as a core framework guiding the development of a working cross-cultural competency for intervention with ethnically diverse populations.

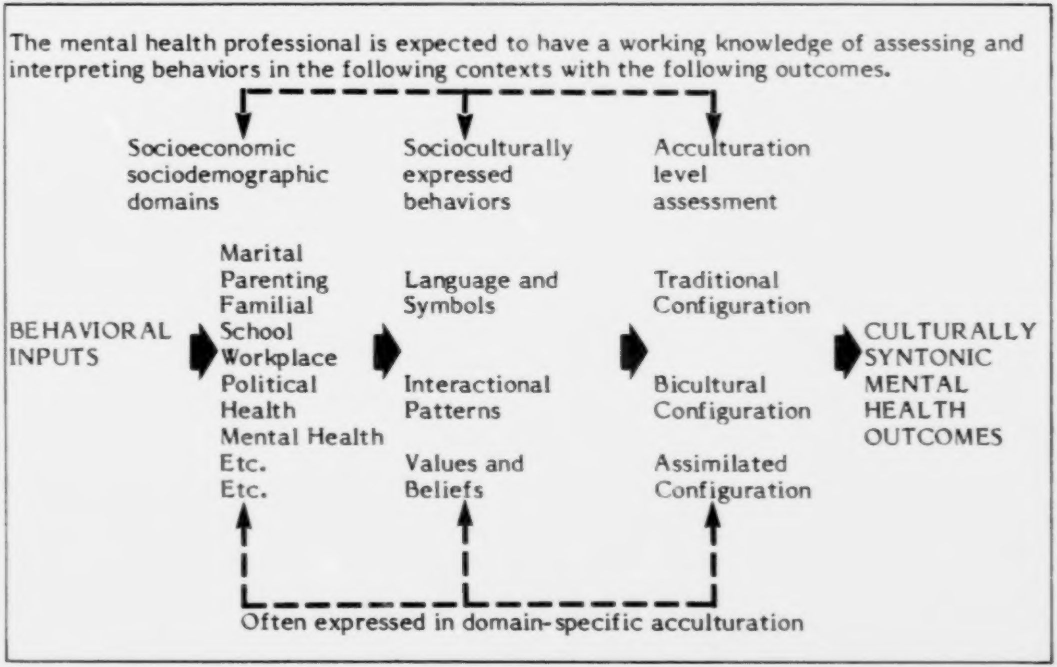

The mental health professional is expected to have a working knowledge of assessing and interpreting behaviors in the following contexts with the following outcomes.
Socioeconomic sociodemographic domains
Socioculturally expressed behaviors
Acculturation level assessment
BEHAVIORAL INPUTS
Marital
Parenting
Familial
School
Workplace
Political
Health
Mental Health
Etc.
Etc.
Language and Symbols
Interactional Patterns
Values and Beliefs
Traditional Configuration
Bicultural Configuration
Assimilated Configuration
CULTURALLY SYNTONIC MENTAL HEALTH OUTCOMES
Often expressed in domain-specific acculturation

Figure 2-1. A cross-cultural competency model for mental health

The desired outcome would be the mental health practitioners' and/or researchers' ability to identify, sort, and incorporate those ethnocultural attributes into their interventions.

PRACTICAL APPLICATIONS

Hispanics might serve as a case in point. The cultural issue at stake here is to avoid professional service or research interactions that generate a sense of dependency, so that recipients will use assistance provided for survival or development purposes. From a cross-cultural perspective, these exchanges must be negotiated. Here the cross-culturally competent professional, wary of damaging the potential recipient's orgullo (cultural pride) and of stimulating feelings of vergüenza (sense of personal shame) would seek an "exchange/negotiation" approach, aiming to convey an attitude of respeto (respect) for the recipient. One way to do this is to indicate to the potential recipient that the social and/or material resources or "goods" will go to waste if not used immediately. This type of "exchange/negotiation" behavior around service provision or research activity also takes the form of negotiating "permission" with the recipient to be of help or assistance. Here there may be a lack of understanding between the mainstream-oriented professional and the bicultural- or Hispanic-oriented professional. Within the United States, with its emphasis on entitlements and rights to certain kinds of formal supports--particularly to programs, such as the social insurances, to which consumers have contributed--it is not "culturally logical" for the provider to have to "negotiate" the use of services with potential consumers. To the Hispanic living with traditional cultural values and subscribing to certain normative attitudes aimed at maintaining personal dignity and avoiding psychological dependence, it is "culturally illogical" or worse, "culturally offensive" to become dependent upon services.

Extreme positions in cross-cultural understanding have been drawn here. Obviously, as discussed earlier, Hispanics have been exposed to a variety of acculturative influences that might well serve to mitigate some traditional attitudes. For example, the Hispanic in the work force may be familiar with Social Security and other retirement benefits. What is important to recognize is that despite this exposure, residuals of the normative outlooks of orgullo can still be expected to carry over into interactions with formal human service delivery systems, especially mental health services.

The issue could be explored and debated for the remainder of the paper. What is germane to the discussion here is that the mental health professional must remain aware that for Hispanics--and by extension, members of other ethnic groups--help-seeking and help-accepting behaviors arise from value orientations different from those of the U.S. cultural mainstream.

From an overall perspective using Maslow's (1954) formulation, it is evident that Hispanics, as well as members of other ethnic groups, experience the same needs for companionship, for unconditional regard, and for intimacy as do members of majority cultures. Social networks and the social support they can provide evolve to meet this need. In fact it would be difficult to find a society that had not developed primary group/natural-informal social structures to meet such needs. But it would likewise be difficult not to encounter extremely varied natural social network configurations among different cultural groups. It is here that cultural uniqueness comes into play, as does the need for cross-cultural interventive knowledge and skills on the part of the mental health professional. In essence, cross-cultural competency becomes the ability of the practitioner or researcher to recognize the unique variations of common human themes as they are played out within specific cultures and at specific sociohistorical points.

OBSTACLES AND BARRIERS

It would be remiss not to focus on a number of key obstacles to the dissemination of cross-cultural knowledge and interventive expertise throughout the field of mental health. The first emerges around what could be termed the politics of knowledge and the issues of paradigm control with regard to scientific discovery and change as outlined by Kuhn (1970), and by Rogers and Shoemaker (1972) with reference to the problems attendant upon the dissemination of innovation. The second major obstacle is the uneven quality of the existing information about U.S. ethnic minority populations. This unevenness is reflected in the lack of validated baseline data upon which to ground the curricula of the mental health disciplines.

The third barrier is the resistance to change among practitioners and researchers at all levels of the mental health establishment. This last barrier, however individual in nature, serves as a collective obstacle to implementing cross-cultural competency throughout the field of mental health. All of these barriers can be subsumed under one heading, the "politics" of knowledge change, which must be addressed if a cross-cultural competency model is to be implemented within the training curricula of the core disciplines in the field of mental health.

The Politics of Knowledge Change and a Curriculum Infusion Strategy

In his analysis, Kuhn (1970) offers a cogent discussion of the politics of knowledge and the forces surrounding the introduction of changes in the core paradigms of any fields of knowledge or group of disciplines. The resistance of the adherents of the dominant paradigm is formidable. This has been evident in any historical era, ours not excepted. The methods of inquiry that currently dominate the social and behavioral sciences do not readily permit the presence, let alone the potential infusion, of knowledge acquired through other methods, such as ethnomethodological approaches. These latter have to date served as the primary contributors to cross-cultural curricula in mental health. The same level of struggle and opposition is experienced in the introduction of traditional (folk) medicine and within the prevailing medical model of "orthodox" Western medicine. The knowledge emerging from alternative areas of thinking and practice is not generally well received.

Rogers and Shoemaker (1971) have discussed the problem from still another standpoint, namely, the problems of diffusing innovation. They note the very strong resistance to the introduction of new techniques in the face of existing, so-called "tried-and-true" methods, not only in industrialized societies but also in more traditional societies. In either society the adherents of the dominant paradigm(s) harden their positions against acceptance of the emergent change. Resistance can be collective or individual. In the field of mental health, ethnic minority content can be detained, as it has been, at the periphery of the various disciplines that make up the field, or resisted in the classroom by the individual instructor or by the total program. Members of the more traditional belief systems can also hestitate to enage in the new ways.

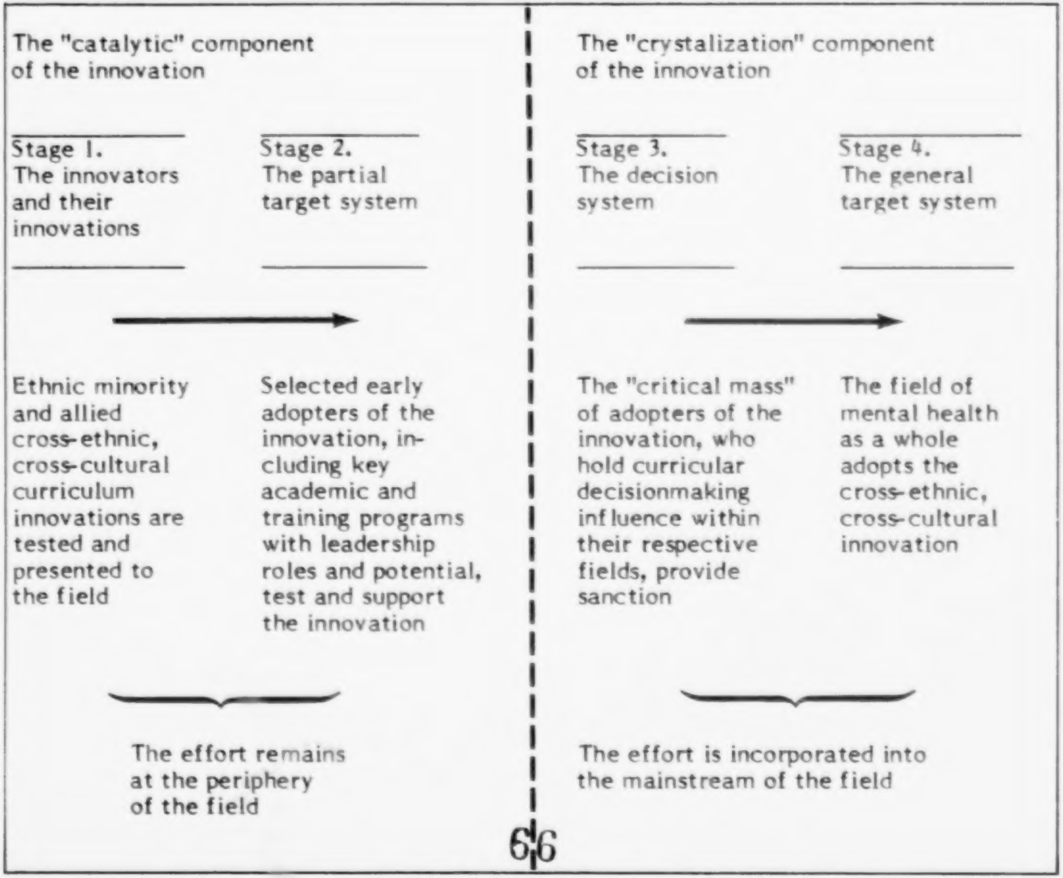
As both Kuhn and Rogers and Shoemaker indicate, though, and as history attests, the siege mentality of the dominant paradigm is not at all successful over the long run. A case in point would be the scientific method based on generalizable empirical evidence, which we have labeled the "dominant" social and behavioral science paradigm. When the approach surfaced in 17th-century Europe, resistance was extensive. Now this "newcomer," which has proven of great use to society in general, finds itself under challenge, with every indication that major changes are underway, if the field of quantum physics is any indicator. The difficulty for us is the fact that, while we may agree with Kuhn's notion of the relative inexorability of knowledge and social change, we find it quite difficult to wait the many years it takes for evolutionary forces to work out the necessary changes.

This is very much the case in mental health. We already have 2 or more decades, dating from the 1960's, of attempting to influence the field of mental health to incorporate knowledge and practices syntonic to ethnic minority populations. With regard to the cross-cultural knowledge change agenda in mental health, we can push the timeline further back to the work of Kardiner (et al. 1945), Seward and Marmoor (1956), and Leighton (1961) to name but a few of the earlier contributors. In the interest of expediting the process, what, then, are we to do?

In their examination of the issue Rogers and Shoemaker propose that the process of change can indeed be accelerated. It can be accelerated if attention is paid to systematic methods for introducing the change. Figure 2-2 presents a modified summary of their suggested approach, as well as that of other social change theorists (Rothman et al. 1977), which can be termed the "targeting of innovations."

From the perspective of this writing we are still very much at Stage 1. We have only begun to consider strategies and approaches germane to raising the quality and level of ethnic syntonic knowledge in mental health to Stage 2. Perhaps here and there specific programs within particular mental health disciplines have progressed much further into the change process. But current experience in the field of curriculum development would indicate that we have some distance to go in just identifying those significant "early adopters" who will model the proposed innovations--and who themselves, or whose programs, have sufficient stature to influence the mainstream curriculum decisionmakers and their professional training systems. And from there we have a further step to attain, namely, influencing the faculty professionals in the field to incorporate cross-cultural knowledge and skills into their everyday practice.

The issue is how to proceed in an economical, non-aggressive, well-planned way. After all, just how much can we pack into an already-crowded professional training curriculum! There are some solutions at hand. The concept of acculturation as outlined in figure 2-1 offers a possible start toward the solution of the dilemma. As Benedict (1934), Kluckhohn (1962), Herskovitz (1972), and a host of others have indicated, cultures are dynamic. They are always in process. Acculturation and change are likewise also always present in some form. As reported in the literature, individual mental health professionals as well as some specific programs--including some academically based programs--have found the way to establish culturally syntonic working linkages with ethnic minority populations. With this in mind, the mental health leadership might consider a concerted effort to implement Stage 2 of the Targeting of Innovation Strategy suggested in



The "catalytic" component of the innovation

Stage 1. The innovators and their innovations

Ethnic minority and allied cross-ethnic, cross-cultural curriculum innovations are tested and presented to the field

Stage 2. The partial target system

Selected early adopters of the innovation, including key academic and training programs with leadership roles and potential, test and support the innovation

The effort remains at the periphery of the field

The "crystalization" component of the innovation

Stage 3. The decision system

The "critical mass" of adopters of the innovation, who hold curricular decisionmaking influence within their respective fields, provide sanction

Stage 4. The general target system

The field of mental health as a whole adopts the cross-ethnic, cross-cultural innovation

The effort is incorporated into the mainstream of the field

Figure 2-2. The strategic targeting of innovations

figure 2-2. It is true that this approach would leave the overall effort still at the periphery of true cross-cultural curriculum change in the field of mental health and leave us still somewhat distant from the development of a functional critical mass of adopters. But a considerable number of ethnic minority curriculum innovators are already reported in the literature. It is time to formally activate selected exemplars who will serve as partial target system precursors for decisionmakers and the field as a whole.

CLOSING NOTE

It is one thing to have a notion of the core competencies required for cross-cultural practice as outlined in the initial portion of this discussion. It is another to have a working model through which to implement these competencies. Both steps fall flat, though, if the actual "politics" of knowledge change are not meaningfully addressed. We will be left in such a situation unless we address the issue of cultural equity. Our current mental health policies and programs are monocultural, that is to say, respondent to mainstream U.S. culture in structure and function. They deny the pluralistic nature of our society and the hetero- geneity of the Nation's ethnic minority populations. Flexibility is not a key note of either the service or the research establishment within the field. Little formal attention is paid to making these mental health resources accessible to minorities whose language and customs are different than those of the majority. This situation could be reversed through the acceptance of the principle of cultural equity in mental health. We must first accept the right of social subgroups to "be as well as to remain ethnically different," and second, to positively implement a fieldwide effort to train cross-culturally competent professionals.

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CHAPTER 3

RECENT ADVANCES IN AMERICAN INDIAN MENTAL HEALTH RESEARCH: IMPLICATIONS FOR CLINICAL RESEARCH AND TRAINING

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INTRODUCTION

This paper considers the implications of recent advances in American Indian and Alaska Native mental health research for future clinical practice with this special population and for training culturally competent providers to meet their particular service needs. It begins with a brief overview of the demographic, socioeconomic, and health characteristics of the Indian and Native population, with subsequent emphasis on epidemiological patterns of psychiatric illness. The discussion then turns to the state-of-the-art diagnoses, treatment, and prevention of serious psychological dysfunction and major mental disorders among American Indians and Alaska Natives. Diagnostic issues are discussed in terms of research findings about specific assessment techniques, particularly the administration of standard self-rating scales and interview schedules, as well as efforts to develop more culturally relevant instrumentation. Though there is relatively little empirical evidence as to the effectiveness of specific therapeutic modalities, some albeit limited attention, has been paid to psychoanalytic procedures, group therapy, and family network intervention with Indian and Native patients. This evidence is reviewed, as are several culturally specific forms of treatment that have been introduced into formal service delivery settings. Treatment issues, however, are yielding to a growing interest in preventive and promotive strategies. This interest is chronicled with an emphasis on interventions that hold considerable promise for enhancing the psychological well-being of American Indians and Alaska Natives at various stages of the developmental life cycle. After the relevant diagnostic, treatment, and prevention research are discussed, the paper next describes a psychiatric residency training program that incorporates these types of findings into its curricula. The knowledge, skills, and attitudes highlighted in this training program provide special insight into the issue of cultural competence in mental health practice among Indians and Natives. The discussion closes by inventorying a series of major questions that should be considered in developing psychiatric and clinical psychology curricula for preparing mental health professionals to practice among American Indian and Alaska Native communities.

DEMOGRAPHIC, SOCIOECONOMIC, AND HEALTH CHARACTERISTICS

American Indians and Alaska Natives constitute a dispersed, mobile, young, and rapidly growing population. This particular minority group is considerably smaller in number than others, notably Blacks, Hispanics, and Asians; however, its special status derives from a long history of legal and moral federal responsibilities.

The 1980 census indicates that the Indian and Native population numbers approximately 1.5 million, nearly double the 1970 count (U.S. Bureau of the Census 1981). If past trends have continued, slightly more than half live in rural areas, on reservations, or native lands. Indian and Native communities are culturally heterogeneous, having been classified into distinct regions; these regions vary from 9 to 17 depending upon the criteria applied in terms of language, social organization, religious practice, and ecological relationships. One hundred and forty-nine of the over 200 major native languages that existed immediately prior to European contact are still spoken. Presently there are 356 federally recognized tribal entities; an additional 65 have not been assigned tribal status by the states in which they reside, and several dozen others are not formally recognized in any fashion.

The Indian and Native population is remarkably young. The median ages of American Indians (20.4 years) and Alaska Natives (17.9 years) are significantly less than that of the U.S. population in general (30.3 years) (U.S. Bureau of the Census 1981; Broudy and May 1983). Infant mortality and infectious disease death rates have declined dramatically in recent years (Indian Health Service 1978), rendering the consequences of chronic physical illness, poor mental health, and alcohol abuse more obvious and of greater service priority.

By and large, American Indians and Alaska Natives are economically impoverished. In 1970 the annual median income for Indian men 16 years and older was $3,509; it was less than half that amount for both Indian women and older Indian adults ($1,554 and $1,688, respectively). Though the ensuing decade recorded substantial economic gains for the general population, the mean family income within this special population ($6,857) remains less than half that of the average for white families (U.S. Office of Health Resources 1977). It is not surprising, then, that unemployment is extremely high among Indians and Natives, ranging from 60 percent to 70 percent in some communities, to a low of 20 percent in the most prosperous ones.

The average number of years of formal education received by American Indians and Alaska Natives (9.6 among those 25 years and older) is well below the national average (10.9 years) and is the lowest of any major group in the United States (Brod and McQuiston 1983). Dropout rates between the eighth and ninth grades have been observed to exceed 48 percent in a number of public schools (Mason 1968, 1969) and even higher at Bureau of Indian Affairs boarding schools (Shore 1972).

Arrest rates of Indians and Natives are among the highest in the nation. In urban areas, Indians are taken into police custody at a rate four times greater than that of blacks and 10 times that of whites, largely for alcohol violations, vandalism, sex offenses, and auto theft (Jepsen et al. 1977). The Uniform Crime Reports over the last decade show American Indians and Alaska Natives to be above the national norms in arrests for liquor law violations, drunkenness, disorderly conduct, and vagrancy (U.S. Department of Justice 1976).

PREVALENCE OF PSYCHOLOGICAL DYSFUNCTION AND MENTAL DISORDER

The prevalence of alcohol and drug use among American Indians and Alaska Natives varies tremendously from one tribe to another and by age within tribes (Heath 1984, Leland 1976, Levy and Kunitz 1974, Mail and McDonald 1980, May 1977, Oetting et al. 1980, Oetting et al. 1983). However, this observation does not diminish concern for the extent to which alcohol and drug use contribute to morbidity and mortality in this special population. Alcohol abuse is a major factor in 5 of the leading 10 causes of death among most tribes. For all alcohol-related causes of death, the U.S. Indian-adjusted mortality rates are higher than those for the nation. Vehicular fatalities are 5.5 times higher; alcoholism is 3.8 times higher; cirrhosis of the liver, 4.5 times higher; suicide, 2.3 times higher; and homicide, 2.8 times higher (May 1986). The majority of Indian youth have experimented with alcohol (56 percent to 89 percent), report more frequent use of marijuana than other U.S. youth (41 percent to 62 percent compared with 28 percent to 50 percent), and abuse inhalants more often than non-Indian youth (17 percent to 22 percent compared with 9 percent to 11 percent) (Oetting et al. 1980, Oetting et al. 1983, May 1983). This pattern of use clearly contributes to the finding that Indian and Native deaths from alcohol-related causes are most common in the younger years. Alcohol abuse also figures importantly in morbidity as a significant health problem. Inpatient and outpatient data from the Indian Health Service indicate that alcohol-related trauma and diseases are frequent reasons for health care and disability among many tribes (May and Broudy 1980).

The picture is not much brighter with respect to mental health problems per se. Three community-based psychiatric epidemiological studies have been conducted to date among adult Indians and Natives (Shore et al. 1973, Roy et al. 1970, Sampath 1974). Each study reports alarmingly high rates of serious psychological dysfunction and major mental disorder, ranging from a low of 27.3 cases per 1,000 to a high of 373 cases per 1,000. Depression and adjustment reactions consistently are the most prevalent problems. The burgeoning literature on Indian suicide attests to this dysfunction's special place among the mental health concerns of Indians and Natives. Peters' (1981) recent bibliographic review identified 65 publications on Indian suicidal behavior. Shore (1975) has shown that annual completed suicide rates vary from 8 per 100,000 in the larger tribes of the Southwest to 120 per 100,000 in the smaller tribes of the Intermountain West.

Studies of mental health service utilization do not necessarily reflect community-wide rates of psychological dysfunction or serious mental illness. However, they offer additional insight into the nature of problems that are present. The U.S. government initiated mental health programs for American Indians and Alaska Natives in 1965. By 1977, 40 reservation mental health programs were supported by the Indian Health Service (IHS). In that same year there were 60,000 visits by Indian and Native patients to these outpatient facilities (Beiser and Attneave 1978). One-third to one-half of all patients visiting the programs in question were treated for depression. A more recent report of the utilization records of the same outpatient mental health services revealed that 38 percent of the visits were attributed to depression, anxiety, and adjustment reactions (Rhoades et al. 1980). An unpublished summary of a random sample of patient caseloads in three urban health clinics indicated that 30 percent of the presenting complaints were attributable to mental health problems (Urban Indian Health Care Association 1979). Sue (1977) in a study that surveyed 17 community mental health centers in Seattle, Washington, found diagnostic patterns consistent with those noted above. More disturbingly, he noted that 55 percent of the Indian patients seen in these centers were highly unlikely to return after their initial contact; a more significant dropout rate than demonstrated by the black, Asian, Hispanic, and white patients.

Given the prevalence of such major mental health and alcohol problems among American Indians and Alaska Natives, the reader may be surprised by the relative lack of systematic attention to widely recognized cultural differences in the Indian life experience which influence either the psychiatric assessment or treatment of this population. Concerns in this regard date to more than two decades ago, but as yet have had only a modest impact on current clinical practice.

DIAGNOSIS AND ASSESSMENT

Numerous assertions appear in the literature as to the unsuitability of standard diagnostic instrumentation for use with American Indians and Alaska Natives. However, apart from anecdotal observations, very little empirical evidence is available that speaks directly to either side of this issue. Until quite recently, the most concrete findings have emerged from studies primarily concerned with describing relationships between mental health status and other phenomena such as culture change, alcoholism, and physical well-being. In the course of these studies, the investigators have considered the psychometric characteristics of several measures of dysfunction or disorder largely by using self-rating scales, namely, the Cornell Medical Index (CMI), Langner 22-Item Symptom Inventory, Health Opinion Survey (HOS), and Minnesota Multiphasic Personality Inventory (MMPI). Few consistent findings have emerged in regard to the reliability and validity of these measures when employed with American Indians and Alaska Natives.

The CMI is a widely used health questionnaire that comprises 18 sections totaling 195 questions (Brodman et al. 1952). The first 12 sections (A-L) focus on symptoms specific to discrete physiological systems; the remaining six sections (M-R) address psychological symptomatology. Chance (1962) employed the CMI to examine the effects of rapid social and cultural change on mental health and illness among the 100 Eskimo residents of an isolated Alaskan coastal village. Mindful of cultural differences between this population and that for which the CMI was originally designed, Chance began his study with a careful analysis of the conceptual clarity, terminology, and response format of the questionnaire items. Thirty-eight items proved to be meaningless, because either the Eskimo residents could not have understood them ("have you ever had jaundice?") or had not had the requisite experience to reply logically to the question ("has a doctor told you your blood pressure is too low?"). Some questions were revised to be consistent with local idiomatic expressions. For instance, "is your nose continually stuffed up?" was altered to read "is your nose plugged very often?" Questions relating to impairment also were changed to better reflect behavioral differences in the tolerance of certain kinds of problems. As an example, since Eskimos rarely, if ever, go to bed with a cold, the question "when you catch a cold, do you always have to go to bed?" was converted to "when you catch a cold, do you always have to take it easy?" Finally, a series of words such as "swollen," "dizzy," "tremble," "paralyzed," "nervous," and "crippled" necessitated the translation of the English connotations into Eskimo. Chance recognized that even conceptually meaningful questions were subject to different cultural interpretations. Given the Eskimo emphasis on tolerance, patience, and endurance, their endorsement of questions dealing with impairment ("does sickness often keep you from doing your work?") was thought to be a much more potent indicator of distress than similar responses by whites. Cultural differences in appropriate sex-role behavior also affected the interpretation of item responses. Women, for example, who answered affirmatively to "do you always feel like you need someone to help you make up your mind?" were consistent with their passive role in Eskimo decisionmaking and were not expressing feelings of inadequacy, as presumed by the question. Based on these findings, Chance argued that the CMI and other instruments like it are of questionable validity when administered to populations that are culturally different from those for which such instruments were originally developed.

Martin et al. (1968) used the CMI and the Langner 22-Item Inventory to screen 571 Indians, 208 whites, and 70 blacks attending Indian Health Service and university medical outpatient clinics in Oklahoma. Unlike the isolated Eskimo villagers with whom Chance worked, the Indian respondents in this survey were relatively literate and educated, averaging slightly more than 7 years of formal schooling. As one might expect, given the differences in level of acculturation, Martin and his colleagues encountered far fewer problems in the administration of the CMI to their population than did Chance. Yet a few items presented some difficulty even for the more literate Indian respondents: "Do you have an uncontrollable need to repeat the same disturbing actions?"; "Do you always do things on sudden impulse?"; "Is the opposite sex unpleasant to you?" Martin et al. concluded, however, that subsequent revisions of these questions resolved problems in their interpretation: "Are there things you can't help doing?"; "Do you always do things without thinking?"; "Do you dislike the opposite sex?" It remains unclear whether or not one can assume that these revised questions are equivalent to the originals. More minor substitutions also were deemed effective, namely, "boss" for "superior" and "trouble" for "difficulty." The investigators acknowledged that some respondents were bothered by the adverbs "usually" and "always," which may be a comment about cultural differences akin to Chance's experience with attributions of impairment among the Eskimo. A test-retest of the CMI with a subsample of 55 Indian respondents over a 4-week interval revealed a high correlation between the first and second set of CMI scores. Subsequent psychiatric interviews of a different set of 50 Indian patients indicated marked agreement between CMI score and assignment of a diagnosis. In addition, the Langner 22-Item Inventory was administered concurrently to 34 of these 50 patients. The two measures exhibited better than 90 percent agreement in the respective estimates of suspected cases and noncases. Given these results, Martin et al. decided that the CMI and Langner scales constitute relatively effective means of screening for emotional disturbance in the Indian population. Recently emerging work by Wheaton (1982) and Roberts and Vernon (1984)--(unfortunately American Indians were not studied)--vividly detail the limits of this latter instrument as a measure of psychiatric disorder, its susceptibility to response bias, and confounding by physical health problems.

The HOS was developed as part of the seminal Stirling County Study (MacMillan 1957) and was adapted from the CMI. It originally contained 75 items cast in a "yes/no" format that emphasized largely psychophysiological complaints; a shortened, 20-item version is used more commonly for general population screenings. Murphy and Hughes (1965) examined the HOS as a method for eliciting indicators of emotional disturbance among Eskimos living on St. Lawrence Island in the Bering Sea. The investigators began by critically reviewing a core set of 20 questions thought to be culturally universal in application. Their discussion of these questions was organized in terms of those (1) centering on views, practices, and patterns of physical illness, (2) those specific to food and the gastrointestinal tract where diet habits might be relevant, (3) those in which wording might influence response, (4) those in which cultural practices might be pertinent, and (5) those that do not appear to be distorted by cultural practice or physical considerations. After careful ethnographic analysis and limited pretesting, Murphy and Hughes concluded that 10 questions were appropriate in the original form for use with St. Lawrence Island Eskimos: present health trouble, susceptibility to disease, vitamin pills, patent medicine, loss of appetite, "hands tremble," "hands or feet sweat," nervous breakdown, "sick headaches," and "trouble sleeping." Eight questions were found to be either unintelligible because of wording ("tired mornings," "ailments all over") or inappropriate because of local norms (smoking, "arms and legs asleep," upset stomach, "heart beating hard," "cold sweats," and nightmares). The latter questions were recalibrated to take into account the different levels of impairment associated with the Eskimo life experience, as previously discussed in relation to Chance's work. Two items ("bad taste," "food tasteless") proved to be equivocal and drew no clear recommendation. Having revised the HOS accordingly, Murphy and Hughes then surveyed the entire village and compared the results with those from the Stirling County Study. They found that 12 questions had similar distributions of responses for both groups and argued consequently that these items can be considered as equivalent in meaning for St. Lawrence Island Eskimos and Stirling County residents. The 12 questions included the 10 initially thought to be appropriate and the two items "bad taste" and "food tasteless." Items concerning palpitations and nightmares proved to be effective indicators of distress. Eskimo response patterns on four questions ("tired mornings," "arms and legs asleep," upset stomach, smoking) differed markedly from those of the Stirling County residents and thus were deemed inappropriate for psychiatric investigation. Murphy and Hughes concluded that, properly modified, this particular instrument is useful for the study of mental health across different cultural lines.

Several other psychiatric investigators have employed the HOS with Indian and Native communities, though none of them considered its psychometric properties in as great detail as Murphy and Hughes. Shore et al. (1973) included the HOS in their epidemiologic study of the adult Indian residents of a Pacific Northwest Coast village and found it to have acceptable reliability with independent clinical assessments. Sampath (1974), in his study of a Baffin Island Eskimo settlement, reported similarly high correspondence between HOS ratings and psychiatric diagnosis, but with less reliability in the "moderate" to "mild" categories wherein HOS score bore little relation to clinical judgment. This latter finding is consistent with the observation by Murphy and Hughes that the HOS more effectively identifies "illness" than "wellness."

The MMPI has had a long history of use with American Indians, dating to the developmental phase of the original scales (Arthur 1944). Moreover, mental health professionals in the Indian Health Service, the largest single provider for this special population, employ this particular diagnostic tool more frequently than any other to assess patient status. Despite an early and extensive interest in the MMPI, only five studies have been conducted that shed any light on its psychometric properties with Indians and Natives.

Pollack and Shore (1980) reported findings from a study of the MMPI involving 142 American Indian psychiatric patients seen by various clinics in the Portland Area Indian Health Service. The mean profile for the respondents reflected significant elevations in the F, Pd (psychopathic deviate), and Sc (schizophrenic) scales, with the latter two scales being consistently among the three highest for the 11 different subgroups (defined by age, sex, diagnosis, and culture area) that were of interest to them. Differences by age, sex, diagnosis, and culture area were observed in degree of apparent pathology as reflected in the relative elevation of scale scores. However, Pollack and Shore felt that the overriding similarity of profiles across all of the subgroups suggests that the MMPI performs differently with American Indians than with white psychiatric patients and that, among the former, cultural factors mask pathological differences.

Butcher et al. (1983) systematically compared MMPI scale scores and mean profiles for 97 black, 454 white, and 36 American Indian psychiatric inpatients treated at a major medical center in Minnesota. Examining the total groups as well as subsamples matched on the basis of socioeconomic status, they found significantly higher scores for blacks than for either whites or Indians on the F, Pa (paranoia), Sc, and Ma (hypomania) scales. Indian patients never scored significantly higher than white patients on any of the scales. Indeed, significantly lower scores for Indian patients than white patients on the Pt (psychasthenia) and Sc scales, in combination with the previously mentioned pattern for blacks, prompted Butcher et al. to infer that the MMPI does not "overpathologize" nonwhites and that group differences in MMPI scores probably reflect self-reported symptom differences for certain types of psychopathology.

Kline et al. (1973) administered the MMPI to 30 male Indian alcoholics being treated in an inpatient program. One-third of the respondents had five or more T scores above 70; two-thirds of the respondents had three or more T scores above 70. Kline et al. observed consistent elevation of the F, Pd, and Sc scales. The greatest degree of pathology was evidenced among respondents with a major elevation of the Sc scale; the least was found among those with elevated Pd and D (depression) scales. The MMPI profiles of the respondents in this study were significantly more elevated than those of a presumably comparable group of white alcoholic patients. Sufficient ambiguity in the meaning of scale elevation and the diversity of patient profiles led Kline and his colleagues to call for the development of MMPI norms specific to American Indians.

Uecker et al. (1980) conducted a controlled comparison of the MMPI profiles of 40 Indian and 40 white veterans being treated for alcoholism in the same type of clinical setting. Their results revealed similar mean profiles for the two groups, with slightly higher elevations for the white patients on the Pd and Mf (masculinity-femininity) scales. Uecker et al. concluded that the Indian patients' MMPI profiles were congruent with those reported for treated alcoholics in general. Page and Bozlee (1982) described similar findings from their study of 11 white, 11 Hispanic, and 11 American Indian alcoholics seen in a Veterans' Administration residential treatment program. An elevated Pd scale was common to all three patient groups and is consistent with the characterological features frequently attributed to the alcoholic population. The investigators noted an unusual absence of elevated Pd scale combinations among the Indian patients and speculated about the less characterological and more neurotic features of this group than the others on the MMPI.

The literature is virtually silent in regard to the use of structured psychiatric interviews with American Indians and Alaska Natives. The only systematic studies of such instrumentation are just beginning to be reported by Manson et al. at the Oregon Health Sciences University (Shore and Manson 1983, Manson et al. 1985). In this particular case, the investigators are focusing on the National Institute of Mental Health Diagnostic Interview Schedule (DIS) and the Schedule for Affective Disorders and Schizophrenia (SADS).

The DIS is a highly structured instrument that was designed to allow lay interviewers (with 1 week of training) to render 26 psychiatric diagnoses according to the Diagnostic and Statistical Manual III (DSM-III) criteria, Feighner criteria, and Research Diagnostic Criteria (Robins et al. 1981). The DIS employs a descriptive rather than etiological approach to diagnosis; clear standards of severity of symptoms; the exclusion of physical illness, medical experiences, and drug and alcohol use as potential explanations of symptoms; and explicit interviewer probes that reduce information variance. The DIS generates diagnoses on a lifetime basis and indicates if the disorder is current or defined for four time periods: the last 2 weeks, the last month, the last six months, and the last year. The DIS also determines the age at the last symptom(s), the age at which the first symptom(s) emerged, and whether medical care was ever sought for any of the symptoms of the disorders in question. Moreover, the DIS yields a total symptom count across diagnoses and a count of the number of criteria met for each diagnosis, whether positive or not.

The Schedule for Affective Disorders and Schizophrenia (SADS) is a structured diagnostic interview designed for administration by psychiatrists, clinical psychologists, and psychiatric social workers (Endicott and Spitzer 1978). It provides a progression of questions, items, and criteria that systematically rule in and rule out specific diagnoses according to research diagnostic criteria. The SADS significantly reduces the criterion and information variance that contribute to the unreliability of previously available evaluation procedures. There are three versions of the

SADS: a regular version (SADS) that assumes a current episode of psychiatric illness and focuses on present functioning (and 2 weeks prior), a lifetime version (SADS-L) that reviews the individual's entire life as well as current disturbance, and a third version for measuring change (SADS-C).

Manson et al. (1985) are assessing the reliability and validity of a modified version of the DIS and of the SADS-L within a known cases/noncases matched control design that involves reservation communities in Arizona, Oregon, and Montana. Their work with the DIS concentrates on depression, somatization, and alcohol abuse. They have elicited indigenous categories of illness and culturally meaningful symptoms thereof. This information, in turn, has been incorporated into the interview schedule, thereby allowing them to discover relationships between psychiatric nosology and the explanatory models that Indian patients hold with respect to their illnesses. Like Chance et al., Manson et al. conducted extensive pretests of DIS item wording and identified culturally appropriate revisions. These revisions included eliminating unintelligible phrases (e.g., "blue" as a descriptor for dysphoria), refining convoluted questions (e.g., distinguishing among sinful, shame, and guilt), and introducing local equivalents (e.g., adding a traditional healer to the list of professionals to whom one might talk to about emotional problems and considering herbal and magical preparations as forms of medication). Their experience with the revised sections of the DIS indicate that the instrument can be administered reliably by lay community members. Likewise, the SADS-L was used reliably by psychiatrists familiar with Indian patients, but was amplified to provide a more complete history of physical illnesses and personal losses. The preliminary results from Manson and Shore's research indicate a number of clinically important differences between diagnostic criteria and the ways in which the members of these communities organize and label the depressive experience, including impairment threshold for symptom duration, symptom clustering, bereavement practices, and help-seeking behavior. Further inquiry along these lines promises to provide insights into the psychiatric assessment of American Indians and Alaska Natives that lie beyond the limits of those that can be obtained through an exclusive focus on self-reporting measures.

TREATMENT

In the area of treatment, one again finds little empirical evidence as to the effectiveness of a specific therapeutic modality and no information at all about the relative efficacy of two or more approaches. By and large, past reports have been concerned with the following themes: (1) the therapeutic functions of indigenous religious and ceremonial activities, (2) differences in cultural values and implications for counseling, (3) psychoanalytic elements of individual responses to stressful circumstances, (4) the legitimacy of traditional healers as psychotherapists, and (5) the structure and evolution of formal delivery systems. Some, albeit limited attention, however, has been paid to psychoanalytic techniques, group-related therapy, and family network intervention with American Indians.

Devereux's (1950, 1951) description of his psychoanalytic work with Plains Indians is the earliest and most concrete discussion of this topic to date. His writings address "the glaringly obvious influence which cultural factors exert upon the course, goals, and outcomes of psychotherapy with Plains Indians . . ." (p. 412). In this regard, Devereux focused on issues pertaining to transference, to dreams and visions, and to therapeutic objectives. Considering transference first, he began with the assumption that such phenomena result from either a misdefinition of the therapeutic situation, an arbitrary imputation of an inappropriate role to the therapist, or the attribution of an equally inappropriate role to oneself as patient. Devereux then recalled examples of each from his own practice and demonstrated how the correct interpretation of and response to transference behavior among Plains Indians requires an understanding of their familial roles and patterns of social interaction. His discussion of the role and function of dreams is equally sensitive and pragmatic. Devereux pointed out that for Plains Indians dreams often are a prerequisite to embarking on major activities and serve important social goals by building morale and reinforcing certain culturally standardized wishes. He underscored the importance of realizing the degree to which dreams are real for Plains Indians, with clear behavioral consequences, and illustrated their autodidactic and characterological dimensions. Finally, Devereux provided numerous examples of how to recognize and resist the temptation to impose the therapist's own, ethnocentric definition of "health" and "normality" upon Indian patients in the course of their treatment. Boyer (1964), Jilek-Aall (1976) and others have written more recently about various aspects of psychoanalysis with American Indian patients, but none of these efforts approach Devereux's thoroughgoing description and explanation of the inherent therapeutic dynamics.

As Edwards and Edwards (1984) noted, group work is fast becoming the treatment of choice for a number of the programs that serve American Indians and Alaska Natives. Popular explanations of this trend revolve around the natural emphasis on groups in the social ecology of most Indian and Native communities. This relatively new movement contrasts sharply with prior assertions as to the inapplicability of group psychotherapy with this special population. These assertions stemmed from an overgeneralization of "stoic" and "silent" Indian stereotypes; the presumption that an unspoken solidarity among Indians precludes the involvement of non-Indians as either fellow patients or group leaders; and the belief that the social norms that disapprove of setting oneself apart from others will repress the therapeutic expression of fear, weaknesses, or problems. An increasing number of examples of the successful adaptation of group approaches to treating members of this special population suggest otherwise.

Wolman (1970) described and analyzed the interpersonal dynamics of group therapy with male and female Navajo alcoholics at a treatment ward in the Gallup Indian Hospital. She illustrated typical barriers to communication, ranging from simple misunderstandings (e.g., being ignorant of the local meaning of expressions such as "dating," which implies sexual intercourse) and breaches in social decorum (e.g., discussing sexual behavior in mixed sex groups) to the obstructive aspects of interpretation (e.g., interruption of dialogue and shielding of patients from therapeutic demands). More importantly, Wolman recounted her own methods for circumventing these barriers, which hinged on distinguishing between actual patient resistance and her own false assumptions about interpersonal processes among American Indians. McDonald (1975) related an equally detailed account of group therapy with Indian women seen through a community-based organization in San Diego, California. Employing a Gestalt orientation that emphasized "here-and-now" problems, he traced the process by which the group initially explored possible topics, mapped out therapeutic goals, established turn-taking, and ventured personal disclosure. Despite encouraging progress, McDonald observed that group members tended to pay little attention to one another, which he termed "duologue" as opposed to the desired "dialogue." This type of isolation, however, eventually was overcome by suggestion and modeling.

The greatest impetus for group work with American Indians and Alaska Natives currently stems from the rapid growth of alcoholism programs and their particular therapeutic emphases. The Indian Health Service supports 177 Indian and Native alcoholism programs in reservation, rural, and urban communities (Peake-Raymond 1984). The vast majority of these--notably the residential treatment programs, halfway houses, and outpatient services--employ group counseling and support groups to treat Indian and Native alcoholics. Anecdotal observations and personal testimony attest to the value and utility of these techniques. Unfortunately, systematic outcome research has yet to be conducted to determine the nature and extent of their efficacy. Without such evidence, continued programmatic support for this treatment approach may wane, because of the resurging biomedical emphasis given to mental health care.

The third area of treatment emphasis represents a variant on group work and focuses on family network interventions. Attneave (1969) was the first to suggest that therapy with American Indians and Alaska Natives ought logically to proceed within the context of the extended family. The family and nexus of kin relationships, as is abundantly clear throughout the literature on this special population, represent the most potent and lasting socializing influence in the lives of Indians and Natives (Red Horse 1980, Shattuck and Hoffman 1981).

Several recent efforts stand out in the application of family network intervention with American Indians. One, described by Red Horse (1982*a*, *b*), involved mobilizing the extended families of Indian members in crisis to assist in problem recognition and problem-solving, to work through role conflicts, and to provide a collective form of therapeutic support. Red Horse discussed four aspects of the clinical process intrinsic to this intervention: spirituality, immersion, picturing, and joining. The spirituality of Indian families is manifested through traditional ritual activities that symbolically reconfirm long-held values and behaviors. By acknowledging this, Red Horse contended that the therapist is able to focus the expressive functions of the family as a group and thus counterbalance the emphasis on individual instrumental tasks that often impede therapy in this type of setting. *Immersion* refers to the clinician's adoption of an active role within the family system. In this fashion, Red Horse argued, the clinician is able to acquire knowledge about the dynamics of extended families and to demonstrate respect for different family types as well as the cultural aspirations of Indian patients. *Picturing* denotes the process by which families examine and articulate group behaviors that typically operate out of awareness. Red Horse described picturing as an ongoing assessment by family members of their structural organization, highlighting relational patterns that permit the reconstruction of respectful behavior and thereby revitalizing individual members. *Joining* "speaks" to this reconstruction, to reconnecting the fractured elements of the family network. Here, Red Horse noted, the clinician attempts to enable the family to reconstitute, for example, the intergenerational relationships, whether natural or fictive, that enhance its supportive capacities. Other examples of the application of family network intervention with American Indians can be found in Red Horse's (1982) work with young, pregnant, unmarried Indian women.

Many traditional Indian and Native healing practices are gradually being incorporated into contemporary approaches to mental health treatment. Indeed, there is increasing collaboration between health care providers and traditional healers; however, not without the kinds of problems that one would expect from any cross-disciplinary effort (Manson, in press). Three therapeutic strategies have received the greatest attention and invited frequent attempts at integration: specifically, the Four Circles, the Talking Circle, and the Sweatlodge.

The Four Circles refer to a process of visualizing the significant relationships in one's life and stimulating the analysis of these relationships. Presented either graphically or verbally, this procedure involves depicting the Creator at the center of four increasingly larger concentric circles. Moving outward, the remaining three circles encompass one's partner or spouse, "blended" family (e.g., children), and, finally, extended family, job, school, community, and tribe. The therapeutic endeavor--spoken of as the search for balance and harmony--begins by discussing the individual's relationship to the Creator, who symbolizes the source of life. The individual and his or her significant relationships within each circle are then examined in turn. Fleming (1983) describes an example of how the Four Circles are used to identify spousal and parental role strains and to consider priorities in one's social responsibilities.

The Talking Circle is a form of group therapy in which people are typically seated in a circle. No one is allowed to leave the circle once it is "opened" to the work at hand. Sweetgrass, sage, or cedar often is briefly burned and passed among the participants to "purify" themselves in the smoke. The smoke also represents the vehicle by which the participants' intentions and subsequent messages will be carried to the Creator. This act ritually connects the individual, physically and psychologically, to the source of the Circle's power. Connection to the other participants is accomplished by shaking hands, initiated by the leader and proceeding clockwise around the circle. Once this is completed, the leader begins the "talk to the people," sharing his or her innermost feelings, speaking to everyone in general, but to no one specifically. The participants do not reply directly to the remarks shared by any one person; each participant is licensed to spe freely without fear of rejection or contradiction. No interruptions are permitted and each participant may speak as long as desired. The leader may circulate a sacred object such as an eagle feather or talking stick among the participants as they speak, thus enhancing the solemnity of their words and connection to the circle. The Talking Circle is closed by a joining of hands and brief prayer. The group chooses whether or not the matters discussed within the Talking Circle will remain confidential or shared with others.

The Sweatlodge usually is a small, circular dome-shaped structure made of willow poles that are arched, tied together, and covered tightly with blankets, heavy tarp, or animal skins. Heated rocks are placed at the center of the lodge, upon which, during the course of the ceremony, water is poured to produce steam. The participants, traditionally of the same sex, sit within the lodge at its outer edge facing the center. The ceremony lasts several hours and is divided into "rounds." A round begins with the sprinkling of water on the rocks, and continues with prayer, which is initiated by the sweat leader and often involves the other participants, again moving clockwise among them as in the Talking Circle. Once the prayers have been completed, the sweat leader signals the end of the round and the participants exit the lodge for a brief cooling period prior to beginning anew. The sweat physically cleanses the participants and induces a sense of both energy and serenity. The ritual itself may vary, but the central purpose of the sweatlodge is to bring each participant closer to the Creator and to the elemental forces that give meaning to life. The prayers are addressed to "Grandfather," which refers to the Creator and all from whom men and women are descended. The Sweatlodge ceremony reaffirms human kinship with all living beings and the universe in general. Hall (1984) provides a valuable overview of the nature and extent to which the sweatlodge has been incorporated into IHS alcoholism and mental health treatment programs.

PREVENTIVE AND PROMOTIVE INTERVENTIONS

Prevention concepts, especially those that involve mental health promotion and enhancement, have long held the interest of tribal planners and service providers, the Indian Health Service, local as well as national advisory boards, and American Indian and Alaska Native people in general. This interest stems from a community-based sense of self and of others that lends itself to the public health model, which underpins the western health care system introduced into Indian and Native communities through past treaty arrangements (Beiser and Attneave 1978). Moreover, indigenous approaches to health and welfare--at the the levels of the individual and of the tribe--provide fertile ground for the growth of such concepts. Largely for these reasons, then, preventive and promotive interventions have been introduced with increasing frequency into Indian and Native communities. However, despite this apparent receptivity, little research has been conducted on the effectiveness of specific interventions or on the basic coping processes that are most amenable to enhancement.

A recent volume entitled New Directions in Prevention Among American Indian and Alaska Native Communities (Manson

1982) summarizes the status of promotive and preventive intervention research in this special population. The vast majority of this work involves secondary and tertiary prevention efforts, which are excluded from the present discussion. Attempts to promote psychological well-being and to prevent mental illness among Indians and Natives have emphasized children over adults, but are divided almost equally between targeted interventions and generalized competency approaches.

The extensive literature on suicide among Indians and Natives attests to the magnitude of the problem in this population. A number of risk-factor studies have found adolescents to be disproportionately represented among Indian and Native suicide deaths (Dizmang 1967, Dizmang et al. 1974, Frederick 1975, Miller and Schoenfield 1971, Mindell and Stuart 1968). Various patterns seem to emerge in different tribal groups and settings. Younger females committing or attempting suicide by ingesting drugs or toxins, frequently after an argument with or rejection by a significant other, have been determined to be at high risk in some groups (Conrad and Kahn 1974, Harvey et al. 1976, Miller and Schoenfield 1971, Mindell and Stuart 1968, Shore 1972). Adolescent and young adult males also appear to be a high-risk group in some areas (Conrad and Kahn 1974, Levy 1965, Miller 1979, Shore 1972). Studying adolescent suicides among the Shoshone, Dizmang et al. (1974) found familial disorganization to be problematic among many victims. Having more than one caretaker before age 15, multiple arrests of caretakers, losses by divorce or desertion, personal arrests of victims, and attending boarding school at an early age were factors that significantly differentiated victims from controls. Several programmatic attempts to deal with this problem have been reported. Shore et al. (1972) presented the background and development of a suicide prevention center on a Northwest Indian reservation. They found involvement of local authorities, particularly law enforcement agencies, to be crucial to the program's success. Dizmang (1967) also pointed out the importance of involving community "gatekeepers" in suicide prevention efforts. Harvey et al. (1976) significantly reduced suicide attempts in an Alaskan boarding school by utilizing a psychiatric social work team and developing a mental illness/substance abuse prevention program that emphasized student involvement in the program's planning and operation. A crisis center for young Blackfeet in Montana, offering 24-hour drop-in, phone-in, and outreach services, also has been reported as a successful primary prevention of Indian adolescent suicide (Pambrun 1970).

Child abuse and neglect are just beginning to receive attention in the Indian and Native prevention literature. Studies by Oakland and Kane (1973), Ishisaka (1978), and Fischler (1985) indicate that rates of abuse and neglect among Indians and Natives appear to be comparable with those of the general population. Etiological factors are complex and multiple, including cultural misunderstanding, modernization, poverty, situational stress, poor parenting skills because of early break-up of Indian families, alcoholism, unusual perceptions of children, child handicaps, and divorce. Two exemplary child abuse and neglect demonstration programs--one among the Yakima (Robbins 1982) and the other among the Plains tribes of northern Montana (Montana State Department of Social and Rehabilitation Services 1979)--have reported considerable success through the development of an array of primary, secondary, and tertiary preventive services.

Mental health service utilization patterns suggest that antisocial behavior among Indian children and adolescents tends to increase with age (Beiser and Attneave 1982). High school dropout rates, which also increase with age in this population, have likewise been linked to delinquent behavior. A reduction in both delinquency and dropouts was reported among Papago students after initiation of a primary prevention program that included special education, tutoring, parent counseling, and group psychotherapy for potential dropouts (Delk et al. 1974). Thornberg (1974) noted success with a primary prevention program geared to reducing dropout rates among minority youth in a rural Arizona high school. This program involved black, Mexican-American, and Indian students who were identified as potential dropouts in a special academic program that focused on improving self-concept and attitudes toward school. Harvey et al. (1976) also reported success in reducing dropout and expulsion rates through the development and utilization of self-help programs for students with alcohol and severe behavioral problems. A dropout program on the Pine Ridge Reservation that emphasized increased involvement of Indian parents and other adults in the school system, both on a volunteer and paid basis, also reduced truancy and dropout rates (Woodward 1973). These types of prevention programs typically acknowledge the major role that alcohol and drug abuse play in Indian student dropout and delinquency, but seldom address this phenomena in a direct manner.

Trimble's (1984) review of alcohol and drug abuse prevention research reaffirms earlier observations (Manson et al. 1982) as to the paucity of work in this area among Indians and Natives. While numerous indices of morbidity and mortality document the high risk of American Indians and Alaska Natives for alcohol- and drug-related problems, very little can be said about specific patterns of abuse, particularly among Indian women, Indian youth, and urban Indians, or across different culture areas. Less has been written about preventive interventions per se. May (1983) provides the best overview of such efforts in a paper titled "Alcohol and Drug Abuse Prevention Programs for American Indians: Needs and Opportunities" presented at a 1983 conference of the National Institute of Alcoholism and Alcohol Abuse. May distin- guishes among three types of approaches: (1) the reduction of the adverse medical consequences of alcohol and drug abuse, (2) community-based preventive education for reducing alcohol and drug abuse, and (3) multifaceted rehabilitation for chronic abusers. Only the first two are relevant to this discussion. The goal of the first approach is to keep people alive and healthy during the youthful period of experimentation with alcohol and drugs so that they live long enough to moderate their use patterns. In this regard, May describes a number of protective measures that have been adopted in Indian and Native communities including legislation and enforcement to deter alcohol- and drug-related deaths or injuries. His 1976 study of alcohol-related mortality and motor vehicle arrests on seven similar reservations in Montana and Wyoming demonstrated the long-term effects of various prescriptive measures enacted through liquor laws that favorably influenced drinking patterns, morbidity, and mortality. May's (May, in press; May and Hymbaugh 1983; May et al. 1983) pioneering work in the National Indian Fetal Alcohol Syndrome Prevention Program illustrates yet another promising form of preventing the adverse medical consequences of alcohol and drug abuse. The goal of the second approach is to reduce the prevalence of alcoholism and/or drug addiction by reducing the incidence thereof by providing specific, practical, and comprehensive knowledge about alcohol and drug abuse to all levels of the Indian and Native population. Examples of community-based preventive education can be found in many Indian and Native communities. Unfortunately, these efforts seldom move beyond informational pamphlets or sporadic talks in schools or other community settings. Trimble (1984) asserts that educational strategies alone, at least with Indian adolescents, will not be effective. In his view, the relevant information must be coupled with cognitive and behavioral interventions that impact naturally occurring peer networks and that provide Indian youth with a new repertoire of responses for coping with pressure to drink to excess.

Systematic attempts to prevent specific psychiatric disorders such as depression lag even further behind the efforts described above. One of the few preventive intervention studies of this nature focuses on the well established relationship between physical health and psychological well-being. Manson (in press) is modifying, implementing, and evaluating a psychoeducational intervention that is intended to reduce the likelihood that an older Indian person will become depressed as a consequence of chronic illness or physical disability. Designed for a pretest/posttest wait control group, the intervention is based upon an approach to treating depression that is referred to as the "Coping with Depression Course" (Lewinsohn et al. 1978, Lewinsohn and Hoberman 1982, Lewinsohn and Clarke 1985). The "Coping with Depression Course" is conducted in small groups that number from 8 to 10 participants and employ a group leader. It consists of 14 to 16 classes that are held over a 10-week period. Each class lasts approximately 2 hours and involves teaching the participants new ways of thinking about their living environment and about their relationships with other people. Participants are exposed to and practice specific cognitive and behavioral techniques for relaxing, for controlling the anger and frustration they often feel as a result of the difficulty in coping with daily problems, and for enhancing the rewarding aspects of their lives. These lessons are couched in terms of homework assignments and class discussions. In addition to its nonstigmatizing aspects, the course is designed to be taught by a trained layperson.

The prevention studies presented thus far deal with specific problem areas. Several investigators have, however, pursued generalized competency approaches among Indians and Natives that focus on mental health promotion through strengthening coping, adaptation, and interpersonal skills. One promotional program with a family and developmental focus was initiated among the Navajo. Dinges and his colleagues (Dinges et al. 1974, Dinges 1982) designed and implemented an intervention that focused on enhancing Navajo parent-child interaction through the accomplishment of culturally specified developmental tasks. The objectives of this program included promoting cultural identification, strengthening family ties, and enhancing child and parent self-images. Lefley (1974, 1975, 1982) evaluated the effects of a 10-week cultural studies program for Miccosukee children. The program was found to reduce distance between the children's actual and ideal selves, to increase their preference for Indian stimuli, and to increase the correlation between personal and ethnic self-perception. These gains were related subsequently to positive self-esteem and psychological well-being. Kleinfeld's (1973) screening for successful and unsuccessful boarding-home parents in Alaska points to a potential mechanism for promoting warm, supportive interpersonal relationships involving whites with Athabascan and Eskimo students, and, consequently, for improving the latter's school performance as well as emotional health. She provides additional insight into these dynamics with two detailed case studies (1982) of environments--a religious boarding school and a village youth organization--that have had positive socializing effects upon Eskimo youth. The well-known model dormitory project on the Navajo reservation is often touted as the seminal study of mental health promotion with American Indians and Alaska Natives (Goldstein 1974, Oetting and Dinges 1974). The project intervened by employing Navajo rather than white houseparents in the boarding school residences and by significantly increasing the number of houseparents available to the students. The houseparents also were trained to overcome the custodial roles that they traditionally had performed in the dormitory and to reinforce their roles as surrogate parents to the students. Students in the model dormitory project showed higher intellectual development, better emotional adjustment, and greater physical development than students in another, comparable boarding school. Perhaps the most innovative promotive effort, at least conceptually, was reported by Mohatt and Blue (1982); this effort focused upon the close tie between culture change and social pathology in the Lakota communities of the Rosebud Reservation in South Dakota. Working with traditional healers, Mohatt and Blue formulated a series of community-based interventions that sought to reduce the occurrence of various social pathologies by regenerating the tiospaye, an expression of traditional values and Lakota lifestyle. The results of their effort are equivocal, but modest gains are evidenced in the experimental community. Mohatt and Blue's study indicates how cultural revivalism can serve as a behaviorally concrete and symbolically dynamic form of promoting psychological well-being in Indian and Native communities.

TRAINING CULTURALLY COMPETENT PSYCHIATRISTS: THE OHSU EXPERIENCE

The Department of Psychiatry at the Oregon Health Sciences University (OHSU) in Portland, Oregon, is responsible for medical student and psychiatric resident education. Training for the provision of services in cross-cultural settings, specifically Indian and Native communities, is a part of the department's educational curriculum. This emphasis reflects faculty interests as well as experiences, the presence of several Indian communities in the service population, and a long history of collaboration with local tribal mental health programs. The OHSU experience in this regard illustrates one way in which the research described in the preceding sections can inform educational objectives that contribute to the development of culturally competent mental health providers, specifically psychiatrists.

Teaching OHSU psychiatric residents to work effectively in Indian and Native communities occurs within the department's community psychiatry training program, which has been in operation since 1973 (Shore 1975). The community psychiatry rotation consists of a half-time, 6-month experience in the third postgraduate year, plus a 6-month, fourth-year elective. It presumes knowledge and skill in the diagnosis and treatment of the major mental disorders that are acquired in the first two postgraduate years. The Directory of Accredited Residencies summarizes the essentials of an approved psychiatric residency and emphasizes educational experiences in cross-cultural psychiatry by stating, "the curriculum must include sufficient material from the social and behavioral sciences (such as psychology, anthropology, and sociology) to help the resident understand the importance of economic, ethnic, social, and cultural factors in mental illness" (Liaison Committee on Graduate Medical Education 1976, p. 361). This requirement is reinforced by criteria developed by the Psychiatric Education Branch at NIMH for evaluating residency programs (Eaton et al. 1976).

Psychiatric residents at OHSU are placed in a wide variety of field sites of their own choice. Those specific to American Indians and Alaska Natives include tribally sponsored mental health programs on several reservations located within the state, an urban Indian mental health program, and a nearby residential boarding school for Indian students grades 9 to 12. The curriculum includes many aspects of service performed by a psychiatrist in community settings. Emphasis is given to consultation, interdisciplinary team participation, administration, community educational tasks, supervision of co-professionals, and some elements of forensic psychiatry. The skills and knowledge expected of a resident at the completion of this program have been described by Shore et al. (1979) and by Cutler et al. (1981). Educational objectives specific to working in Indian and Native communities are discussed in the next section. Residency performance is evaluated by field site and faculty supervisors on an ongoing basis. This evaluation includes weekly sessions with both types of supervisors to review progress in mastering the requisite knowledge, skills, and attitudes. In addition, psychiatric residents are given an oral examination at the end of their third year. This examination employs two community examiners, a psychiatrist, and a nonpsychiatric mental health professional who evaluate the resident's knowledge of community mental health settings as well as his or her understanding of interdisciplinary and cross-cultural mental health issues.

The OHSU psychiatric residency training program emphasizes six goals for the provision of mental health services to Indian and Native communities. These goals include: (1) allocating culturally appropriate mental health resources, (2) rendering relevant diagnoses, (3) collaborating systematically with nonpsychiatric mental health professionals (including traditional healers), (4) providing culturally sensitive psychiatric treatment, (5) enhancing patient compliance with mental health professional recommendations, and (6) facilitating interagency cooperation.

The educational objectives that contribute to the accomplishment of these goals address specific knowledge, attitudes, and skills.

Considering the knowledge objectives first, the OHSU program seeks to impart information with respect to (1) patterns of illness at the population level and sources of local variation in terms of sociodemographic features of specific Indian communities; (2) indigenous nosologies and etiology, with associated symptoms, and their basis in tribal cosmology; (3) the nature and form of native treatment modalities, including the social structural, psychotherapeutic, and pharmacological dynamics that underpin them; (4) the training and socialization of native practitioners and their own as well as others' views on the efficacy of their work; (5) the array of formal agencies that provide health care to Indian and Native communities, their particular histories, usual areas of responsibility, and positions within broader tribal, state, and federal bureaucracies; (6) major trends in legislation and administrative policy that affect not only the types of services funded, but staffing patterns and locus of organizational control; (7) the barriers--some structural, others social psychological--that can impede collaboration between native healers and nonnative health care providers and the interface of their respective systems, with examples of successful attempts; (8) the role and function of family and kin as lay referral networks, the circumstances under which either exclusive or concurrent use of native practitioners and/or nonnative health providers occurs; (9) patient expectations of the medical encounter, including their attributions to providers on the basis of the latter's sex, relative age, length of residence in the community, and principal means of intervention; and (10) factors that may affect compliance with health care professional recommendations, namely, dietary restrictions, family support, and special views on specific aspects of treatment.

The OHSU experience indicates that knowledge in these areas is a necessary but insufficient condition to enable psychiatrists to practice effectively and appropriately in Indian and Native communities. Certain attitudinal sets also are required. Thus, the department's training program attempts to instill (1) a sense for the importance of self-motivated inquiry into the sociocultural contexts of health care-related phenomena that will continue after training; (2) a definition of professional self that is strengthened, not threatened by cross-disciplinary and intercultural communication; (3) a willingness to work within bureaucratic limitations and to tolerate uncertainty; (4) an awareness of the politicalization of health care services in Indian communities and to accommodate intrusions on one's professional efforts; (5) flexibility in assessing impact on health status, whether at the level of the individual or the community; and

(6) multiple standards for measuring one's own accomplishments, defined in a number of ways, and which reinforce the preceding attitudes.

To be implemented in a productive fashion, the OHSU training program has found that this knowledge and these attitudes ultimately depend upon specific skills. Hence, considerable time and effort are placed upon preparing the psychiatric resident to (1) enter the delivery system with a clear understanding of the health care professional role; (2) recognize his or her possibly multiple constituencies and to maintain the clarity of one's role through continued negotiation with them; (3) work effectively in interdisciplinary contexts; (4) "read" bureaucratic organizations and to move within and across them at minimal cost to one's self or co-professionals; (5) anticipate possible relationships between psychiatric diagnostic criteria and indigenous assumptions about pathology; (6) determine patient expectations towards one's self and assumptions about the services to be provided; (7) collaborate either directly or through referral with native practitioners; and (8) initiate basic program planning strategies that maximize provider agency coordination and community involvement.

These training objectives represent an almost herculean assignment for preparing psychiatrists to work in American Indian and Alaska Native communities. Indeed, this assignment is further complicated by the social, cultural, political, and economic diversity within this special population. Given such diversity, and the constraints it places on generalization, the OHSU training program operates on the assumption that the psychiatric residents entering an Indian or Native community embark on an "ethnographic" study of the setting in which they work, of their relationships to other individuals and agencies, and of the community members with whom they come into contact. Like ethnographers, residents are taught to start their field placement by systematically examining the perceptions that various individuals have of them.

In most reservations, a clinician typically works in a federal, state, or tribal setting. The affiliation of the practitioner's workplace often attributes a "label": IHS "shrink," BIA school psychiatrist, tribal "mental healther." With such labels go several expected behavior patterns that differ in terms of the individuals and agencies that interact with the practitioner. From the patient's point of view, a clinician's behaviors may include constant questioning, being "pushy," never venturing beyond the confines of the office, and ignoring involvement with other parts of the social service and health care system. One's counterparts in other components of the system will expect a narrow concern with psychiatric responsibilities for care, constant maneuvering to restrict service eligibility and, thus, work load, organizational elitism, and a general inclination to treat symptoms rather than address the "causes" (about which opinions vary markedly) of patients' problems. Then, too, the community will presume that the psychiatrist desires a certain detachment from their affairs, will live off-reservation, will socialize only with fellow providers, and will constantly seek to define himself vis-a-vis community members in terms of his professional role.

These expectations are further complicated by the cultural position of the resident. It is fairly straightforward in regard to non-Indians, "whites" in the accepted parlance of both reservation and urban communities. As outsiders, they particularly are expected to conform to the behavioral patterns noted above. In fact, if at first they do not, a serious dissonance arises that the community finds disconcerting and warranting criticism: "He doesn't fit in" or "She isn't doing her job." To the extent that one is less clearly an "outsider," the role expectations begin to shift and can pose major dilemmas for the incumbent. Tribal employees, for example, are expected to be more sensitive to individual needs and more responsive because of their special relationship to the community. IHS and BIA employees consequently will turn over to them the problematic cases, attributing difficulty to some amorphous set of cultural factors. Community members usually feel free to make inordinate demands on tribal providers' time and energy: "Well, after all, she works for us." Popular convention to the contrary, native ancestry does not necessarily imbue one with acceptance or guarantee efficiency of effort.

The psychiatric resident cannot know immediately what expectations fellow providers and the community may have of him or her. The possibilities vary with each setting and community. Thus, just as in ethnographic practice, the resident is instructed to seek out "key informants" within each of the service system components and relevant segments of the community. These individuals can provide "road maps" to the relationships that obtain among the significant elements in the workaday world. The resident, however, is cautioned about this process. First, the resident must assume that these "road maps" reflect their draftsmen's particular histories and perspectives. Hence, one adopts a comparative approach, looking for consistencies (or inconsistencies) among the topographies of the relationships they purport to depict. The psychiatric resident is encouraged to proceed in those areas about which there is the greatest agreement and to exercise caution when moving into relationships that are either poorly charted or characterized by widely discrepant views. Second, the resident is warned that careful attention must be paid to whoever advances himself or herself as a potential "key informant." In many Indian communities there often is an extremely outgoing and friendly individual willing to share well-guarded secrets. To borrow a metaphor from native folktales, this individual is called a "trickster." He or she frequently regales the newcomer with a seemingly unending supply of information--much of it untrue or, at least, unverifiable. The "friendship" depends upon immediate gratification, which is supplied by the rapt attention of the initiate. The wisdom of retaining such an adviser can be determined by studying the manner in which this "trickster" is treated by other members of the community.

Soon after entry to the community, the psychiatric resident is directed to look beyond the study of interpersonal relationships to the ways in which the community is organized, both formally and informally. Certain organizational structures are common in most Indian communities. One is the official tribal council. Many councils were established during the early part of this century with the implementation of the 1934 Indian Reorganization Act. Tribal council offices usually are housed in an agency town, which also contains the facilities of the Bureau of Indian Affairs, U.S. Public Health Service, and many other federal institutions. Tribal governments are virtually identical in form and function across reservation communities. They constitute an indigenous bureaucracy headed by a tribal chairperson who, together with other elected tribal officials and their committees, represent the native constituencies. For this reason, then, the agency town is the nexus of action that affects all communities on the reservation. Decisions are made in the administrative center, can be seen in the flow of office work, and ultimately are carried out to the "districts." The agency town also can serve as an initial point of introduction to less formal community dynamics on the reservation. Many activities are planned in or around the social service and health care program offices, which are typically the largest employers of tribal members. Other focal points for interaction include the post office, the local grocery store or trading post, and school. Here kin networks emerge and informal decisionmaking processes become apparent. An important part of the resident's education involves recognizing these aspects of social organization, learning how they structure community activity, and understanding the roles of different tribal members.

This focused ethnography of the community and one's relationship(s) to it is presented to the psychiatric resident as another important form of assessment not unlike the diagnostic challenge posed by the individual patient. This process becomes the major vehicle in the OHSU program for enabling the resident to acquire the information, attitudes, and skills that are needed to practice effectively in American Indian and Alaska Native communities.

GUIDEPOSTS FOR THE DEVELOPMENT OF TRAINING CURRICULA: QUESTIONS TO BE ADDRESSED

A number of previous publications detail major obstacles to the development of culturally relevant methods for clinical practice with American Indians and Alaska Natives (Manson and Trimble 1982, Manson 1982, Manson et al. 1985, Manson and Dinges, in press). The recommendations that appear in these documents apply equally well to the formulation of appropriate training curricula specific to this special population. Future programs will need to address a series of questions across the topics discussed in this paper, namely, diagnosis and assessment, treatment, and prevention. In dealing with diagnosis and assessment, the curricula should address these issues:

1. How do Indians and Natives perceive serious psychological dysfunction and major mental disorder? What explanatory models do they employ, including (a) indigenous taxonomies of illness; (b) the behavioral, cognitive, and affective components of the illness experience; (c) commonly associated causes and situations; and (d) patterns of help-seeking?

2. To what extent do culturally meaningful definitions of illness among Indians and Natives correspond with DSM-III nosology and diagnostic criteria?

3. Are there predictable relationships among certain forms of dysfunction and disorder that require special diagnostic attention, e.g., alcoholism and depression in Indian males, somatization, and chronic minor depression in Indian females, prolonged grief and major depression in general?

4. How reliable and valid are the prevailing diagnostic instruments for assessing the psychiatric status of Indians and Natives? How can the reliability and validity of these instruments be improved?

5. What relationship does psychiatric diagnosis have with impairment and degree of functioning in this special population?

6. To what extent do the above vary by age, sex, place of residence (urban/rural), tribe, and culture area?

In dealing with treatment, the relevant questions should include:

1. What modalities (indigenous and nontraditional) are being practiced in Indian and Native communities to treat serious psychological dysfunction and major mental disorder?
2. What expectancy variables define these therapeutic relationships, from the Indian patient's viewpoint and from the therapist's viewpoint?
3. What process variables contribute to negative and positive treatment outcomes?
4. How does one appropriately measure treatment outcome?
5. What constitutes effective treatment?
6. To what extent and under what conditions are treatment modalities differentially effective?
7. Under what conditions and for what reasons are traditional healing techniques appropriately introduced into formal treatment settings? How can such techniques be implemented; by whom?
8. Must all therapeutic approaches seek to fit the patient's cultural persona? Or should patients be expected to accommodate the cultural limits of these approaches?

Finally in dealing with prevention, the relevant questions should be:

1. What forms of serious psychological dysfunction and major mental disorder are thought to be preventable? By indigenous means? By nontraditional means?
2. What intervention strategies are being employed in Indian and Native communities to prevent serious psychological dysfunction and/or major mental disorder? To what extent are these efforts being evaluated?
3. How does one appropriately assess preventive intervention outcomes? What constitutes effective prevention?

4. To what extent and under what conditions are preventive intervention techniques differentially effective?

5. What models of competence--in terms of individuals as well as communities--exhibit the best fit with the immense cultural heterogeneity among Indians and Natives? How must these models be altered to explain the role of cultural factors in the organization and maintenance of competent self-systems and collective competencies?

6. How does one appropriately measure competence, at the level of the individual and the community?

7. What are the processes by which such competence is acquired, e.g., the cognitive, behavioral, and situational elements?

8. What is the relationship between individual and/or community competence and the mental health status of Indians and Natives?

9. What intervention strategies strengthen and elaborate upon individual and/or collective competencies?

10. What are the most effective means of educating individuals and communities as to the importance of preventive and promotive efforts? What factors contribute to the assumption of personal as well as collective responsibility for implementing such efforts?

As is evident from the previous discussion of the educational objectives of training programs such as that at the OHSU, a curriculum that addresses these questions will contribute directly to the preparation of mental health professionals to practice competently in American Indian and Alaska Native communities.

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CHAPTER 4

FINDINGS FROM A NATIONAL SURVEY OF BLACK MENTAL HEALTH: IMPLICATIONS FOR PRACTICE AND TRAINING

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ABSTRACT

An understanding of the mental health problems and needs of black and other minority group members continues to be hampered by a lack of empirical research. Even when data do exist, problems of cultural insensitivity, small sample sizes, and inadequate representation of relevant substantive domains makes the adequacy and generalizability of the results questionable. Among the problems contributing to this failure are (1) a lack of awareness and appreciation for the unique cultural experiences of blacks and poor conceptualization of relevant models, (2) an emphasis on race comparative studies with little theoretical or empirical concern for the appropriateness of methods and procedures across different population groups, (3) a lack of attention to obtaining reliable and valid mental health measures, and (4) a dearth of data on large representative samples of black Americans.

The National Survey of Black Americans (NSBA) was undertaken in 1979-1980 to address some of the major deficiencies in previous research on mental health functioning and help-seeking among black Americans. It was believed that a well-designed national community survey on mental health status would provide high quality data not available from previous national population studies. These data could then be used for comparisons with local community studies as well as future national and regional surveys of a similar nature. While scientific considerations dominated the design and execution of the study, the data were considered to be of importance to practitioners in the health care delivery system. Questions were designed to assess the help-seeking process, which included problem identification, distress reactions, individual coping responses, and informal and formal help-seeking.

In the present chapter the nature of serious personal problems reported by the 2,107 black adults in the national sample, the individual coping strategies employed, and the use of informal supports and professional resources are explored. The chapter concludes with suggestions for improving mental health

professional training and service delivery with a particular focus on important social and cultural factors identified in the empirical results.

INTRODUCTION

The purpose of this chapter is to explore the practice and training implications of the findings from a national sample of the black population. The major concern in undertaking this 10-year research effort has been the generation of basic social science knowledge. It is evident, however, that the findings have practice and policy relevance for mental health service delivery, treatment, and training.

Social and economic status indicators document the disadvantaged position of blacks relative to the majority population. However, various mental health outcomes related to these indicators remain the subject of conjecture (Miller and Dreger 1973, Jones and Korchin 1982). One major reason for this void in our knowledge is the lack of comprehensive studies on mental health issues in black populations. These are some of the problems contributing to this failure: (1) A lack of awareness and appreciation for the unique cultural experience of blacks and poor conceptualization of relevant models. While much of black behavior and thought is part of the dominant Anglo culture, much of it is particular and unique to blacks. (2) An emphasis on comparative studies with little theoretical or empirical concern for the appropriateness of methods and procedures across different populations. (3) A lack of attention to obtaining good reliability and validity estimates of various measures of mental health in black samples. (4) A failure to collect date on large and representative samples of black Americans (Jackson et al. 1982).

A major shortcoming of previous studies is the failure to recognize a need for high-quality mental health data on large samples of black Americans. Because of the disproportionate distribution of black Americans in the United States, previous surveys have not attempted to represent blacks in a manner that gives all black households an equal probability of inclusion. Blacks who live in low-density black areas have been particularly excluded. In our national cross-section survey special sampling and screening procedures were developed to ensure a nationally representative sample of all black Americans in the United States (Jackson et al. 1982). An assessment of these procedures has shown them to have been highly effective in generating the national sample and also to be of general utility in the study of any low-density, high-visibility group (Jackson and Hatchett 1986).

In the design and execution of the survey, we attempted, both conceptually and methodologically, to avoid the conventional focus on personal deficits in blacks when examining mental health problems. Instead we have sought to incorporate the influence of past and present systemic constraints. We have also avoided a narrow problem perspective and instead have focused on the adaptive strengths in the black family and individuals.

There has been a great deal of speculation regarding the mental health consequences of the life conditions that blacks face in this society. The early literature focused on the negative psychic consequences of discrimination. More recent literature has been sensitive to the strengths that blacks have exhibited in their history. We were interested not only in the assessment of mental illness and health but also in the analysis of the special stresses and pressures that blacks have faced and of the social supports that helped buttress the effects of these pressures.

Methodologically, we have had to grapple with the challenges of developing conceptual approaches and measures that were valid and meaningful for the black population. The procedures necessary to collect reliable data from a national sample of black Americans had to be methodical yet flexible and responsive to the realities of the black community (Jackson et al. 1982). In this study we were interested in broadly defining mental illness and health to include concepts such as self-esteem and personal efficacy, as well as psychological distress. We felt that a broadened definition was necessary to fully comprehend the social and psychological consequences of discrimination and other forms of prejudicial behavior. Finally, we emphasized the importance of the utilization of resources, since one consequence of a minority status is the lack of congruence between the needs of the group and the available services.

COMMUNITY SURVEYS OF PSYCHOLOGICAL DISORDERS IN BLACKS

Recent community epidemiological surveys have attempted to provide population prevalence rates on discrete psychiatric disorders (Eaton 1981). Although the reliability and validity of this assessment procedure, the Diagnostic Interview Schedule (Robins et al. 1981), with blacks is still open to question (Hendricks et al. 1983), preliminary results from the National Institute's of Mental Health (NIMH) Epidemiologic Catchment Area Program are informative. Both Robins et al. (1983) and Meyers et al. (1983) report finding no significant race differences for schizophrenia or affective disorders. Some differences in phobias have been found (Meyers et al. 1983); the lifetime prevalence rate for agoraphobia

(Robbins et al. 1983) was significantly higher for blacks than whites. On the other hand, Vernon and Roberts (1982) used the schedule for affective disorders and found that blacks in comparison with whites had slightly lower lifetime rates of both major and minor depression but had rates of bipolar disorders that were twice that of whites. One possible explanation for some of these discrepant findings is the lack of national data on race differences in diagnostic analogs. It is clear, though, that not enough is known about race differences in the prevalence of discrete psychiatric disorders.

In our research, we have stressed the limitations in the state of existing knowledge and conceptualizations and the problems of measurement that are exacerbated when comparisons are made across racial and ethnic groups. Therefore, the study that we conducted differed in many ways from the approaches of much of the work in the previous literature. First, a multidimensional perspective on the assessment of mental health was used. Our interest was in the types of distress caused by differential experiences in our society, not in arriving at one overall assessment that indicates the extent of sickness or health. This multidimensional approach makes conceptual sense even in the study of the white majority, but is a particularly important in the study of blacks and other minorities and may help mitigate some of the problems of cross-cultural research in this area. Given such problems as social desirability, language, and cultural definitions of terms, it seems particularly misleading to rely on a single global measure in making comparative mental health assessments. Second, this multidimensional approach implies extending the focus beyond psychopathology. For example, our interviews tapped a wide range of personal problems that people experience and specifically included their feelings of psychological distress from situational factors, not just intrapsychic impairment. We felt that it was particularly inappropriate in studying a discriminated-against population to rely on standard models of psychiatric problems without regard to the environmental life stressors that a racial/ethnic minority group faces. Relatedly, we were also very interested in the sources of personal strength and coping resources that exist among black Americans.

Finally, the fact that we have a broad national sample of blacks enables us to study these issues in different subgroups of the black population. The literature on mental health assessment of blacks has rarely separated the effects of being black in this society from the effects of poverty and lower socioeconomic status that are correlated with race. For example, one community study (Warheit et al. 1975) found that higher black rates on five psychiatric scales were sharply reduced in analyses that controlled for sociodemographic correlates of race. Interestingly enough, the only group of symptoms that did continue to show differences in race were feelings of phobia. We can pursue such analyses more systematically and extensively on our broad national sample. Equally important, this sample enables us to compare mental health indices and sources of strength and stressors in different subgroups in the black population. A major weakness in most of the existing literature has been the tendency to view blacks as a completely homogeneous group. Mental health and illness have rarely been related to varying conditions of black life. This probably helps explain the inconclusive results from the studies of black/white differences on these issues.

INFORMAL AND FORMAL HELP USE AMONG BLACK AMERICANS

One major purpose of our study was to provide national data not only on the mental health needs of black Americans but on how these needs were being met or not met. We were interested in the resources used by blacks in helping them deal with the problems and psychic distress that they experience and formal and informal help resources that they draw upon. We followed a framework that analyzed the decision to use a psychiatric resource by viewing it as the end product of a series of processes; the experience of distress and the definition of distress as a problem requiring help, the type of self-definition that makes psychiatric or other help resources more appropriate, the readiness to disclose problems to others, and the availability of different help resources and attitudes toward them.

Social scientists and health care providers agree that blacks are at risk for the development of mental health problems. While constructive steps have been taken, the mental health care system continues to struggle to meet the emotional needs of black Americans (Snowden 1982, Snowden and Todman 1982). It has also become apparent that continued reliance upon a treatment mode of mental health service delivery cannot do enough to meet the needs of hard-to-reach ethnic minorities. Despite the considerable interest in the mental health and illness in blacks, it is surprising how little empirical research has been done in this area and how equivocable the findings are.

While information is limited, it has been reported in "rates-under-treatment" studies that relative to whites, blacks are more likely to be diagnosed schizophrenic and less likely to receive a diagnosis of depression (Collins et al. 1980; Kramer et al. 1973; Cannon and Locke 1977). The problem with this operational definition of caseness is that differential treatment rates reveal more about the probability of seeking professional help for emotional problems than about differences in the true prevalence of various forms of psychopathology (Fischer 1969).

We did not necessarily expect all black respondents in the national study to evidence unusual, culturally defined approaches to metal illness. There were, however, some possible unique aspects of blacks' definition of the problem that were explored. Particularly, we were interested in whether there were special tendencies for blacks to view problems as externally determined rather than as intrapsychic or interpersonal in nature. In studies of middle class whites, external definitions have been often viewed as externalization and denial. But in blacks they may also reflect the realistic constraints of poverty or discrimination. We were interested in a systematic investigation of the effects of these as perceived constraints on the resource utilization patterns of blacks.

There is a large body of literature delineating the importance of informal community friendship and family members as resources of help in black communities (e.g., Martineau 1977, Stack 1974). In our national study, data were obtained on the extent to which informal resources were used when people were faced with problems that they felt they could not handle by relying on their own resources. We were interested in the extent to which these informal resources were used as alternatives for more formal resources. There is an assumption in much of the literature that friends and family are relied upon instead of formal mental health resources. This is not necessarily true, however. A community study on the patterns of utilization among Americans of Mexican origin concluded that people who use friends and family also use formal help resources (Padilla 1979). The critical issue is whether one turns to anyone for help with serious personal problems.

The extent to which different help resources are utilized by the same people or are mutually exclusive alternatives is a critical issue in the mental health field, particularly since one of the major interests should be in providing nationally based assessments of the extent of unmet mental health needs in the American black population. The problem obviously is more serious if people who do not turn to formal mental health resources when they experience psychological distress also find informal sources of help or support less often. A major objective of our study, therefore, was to provide national data on the interrelationship of the utilization of different health resources. Clearly, as we will discuss in the Implications section, this has important consequences both for delivery of mental health services and for the training of mental health professionals.

Much has been written about the inadequacy of traditional psychiatric facilities for dealing with the problems of blacks, other minorities, and people of lower education and socioeconomic status. Some of these writings note therapists' prejudices that lead to minorities and lower class groups being less often accepted for psychotherapy and typically receiving treatment of shorter duration (e.g., Yamamoto et al. 1968, Lorion 1973). The issue, however, is broader than that of therapist prejudice. Considerable concern has been expressed in the literature regarding the type of treatment available to blacks and Americans of Mexican origin. Many writers have questioned the treatment focus on intrapsychic functioning and point to the need for community-based programs and clinics that are more sensitive to the role of broader social and economic determinants of personal problems.

However, there is little systematic national data on how black people react to this issue and how they view different mental health resources. We were particularly interested in the attitudes and reactions of people who have used some facility or who have knowledge of the experiences of friends or independent family members. The issues regarding help-seeking and the utilization of mental health resources formed the major variables of interest in our national study. Thus, much of the work discussed in this chapter focuses on the processes and factors related to these two broad areas.

THE NATIONAL SURVEY OF BLACK MENTAL HEALTH

The findings discussed in the present chapter are based on national data from the 1979-1980 National Survey of Black Americans (Jackson et al. 1982). This survey was conducted on a nationally representative cross-section sample of the adult (18 years of age and older) black population living in the continental United States. A multistage area probability procedure was used to draw the sample, ensuring that every eligible black household had the same probability of being selected (Hess 1985). This self-weighting, equal probability sample was unique. Historically, procedures have not been available to efficiently conduct an equal probability sampling of the entire black American population.

Sampling and Interviewing

Based on the 1970 Census (and subsequent updates) distribution of the black population, 76 primary sampling area (SMSAs counties) were selected at the first stage. Sample places (Census

Tracts/Enumeration Districts) within these sites were then stratified according to 1970 Census data on racial composition and income. Then, smaller geographical areas (clusters) were selected. Actual screening of households for eligible black respondents and interviewing was conducted in these clusters, generally representing city blocks, groups of blocks, or commensurate-sized rural areas. Preliminary scouting of the selected clusters within each primary sampling area provided a check of new construction, destruction, number of households, and racial composition. In the instances where significant shifts had occurred since the 1970 Census, systematic modifications in the geographical sizes of the clusters were made to maintain the equal probability of selection across all households.

Since correct identification of eligible dwelling units was critical, two special screening procedures were developed and implemented for locating and selecting eligible black households. The Standard Listing and Screening Procedure (SLASP) was applied in mixed and mostly black areas. A large proportion of housing units within these clusters were expected to be eligible. The SLASP was designed to reduce screening costs associated with questioning individuals in every housing unit. This household screening method provided a unique approach to identifying black households by using reference housing units. All housing units in the cluster were identified by informants in the reference dwellings as black or other-than-black occupied. The selection of eligible housing units was then taken from the list of black housing units. A subset of the "other-occupied" housing units were selected for screening to assess the accuracy of the informant information. If a black housing unit was located during this check, then all other-occupied housing units were checked to ascertain their household's racial composition. Adjustments were then made in the housing units selected for interviewing attempts within the cluster to maintain the overall equal probability of selection of black households.

The Wide Area Screening Procedure (WASP) was developed for use in clusters anticipated to have few black-occupied housing units (Jackson and Hatchett 1983). The SLASP results in the listing and racial classification of all housing units in a cluster. In the WASP, specially trained white enumerators entered each cluster and questioned individuals in systematically chosen reference housing units about the location of black households. Maps of the cluster were used to facilitate the location of these housing units. When target households were identified and corroborated by more than one reference housing unit within the cluster, the enumerators then listed only the black-occupied housing units. Selection of dwelling units where interviews were to be attempted were taken from this listing. To evaluate the effectiveness of the procedures, 20 percent of the WASP clusters across the country were chosen at random and received the more thorough SLASP coverage. This verification procedure revealed that only three black housing units were missed. None of these dwellings would have been selected to be in the final sample. Overall, the assess- ment indicated that WASP is a highly cost-effective, efficient technique (Jackson and Hatchett 1983).

The WASP and SLASP permitted the self-weighting national probability sample to be obtained. In the case of WASP, it facilitated, at tolerable cost, the screening of large areas of the country where blacks represented less than 1 percent of the population. Unlike previous national studies, respondents located in these WASP clusters had the same probability of selections as those who lived in more heavily concentrated black areas.

Within each black household selected for an attempted interview, a single person was randomly chosen to be interviewed from a list of all eligible adult respondents in the household (Kish 1965). No substitutions were allowed. A refusal to be interviewed by the selected person resulted in the household being classified as "nonresponsive." All interviewing was conducted by professionally trained black interviewers. This sample and interviewing procedure resulted in 2,107 completed interviews conducted during 1979 and 1980, representing a response rate of approximately 69 percent. The black population is disproportionately distributed within urban areas in which response rates have been traditionally low. The comparatively high overall response rate was obtained by intensifying efforts in these urban areas through repeated interviewer callbacks.

Mental Health Questionnaire

Nearly 2 years were devoted to developing and pretesting the survey instrument. Because we were interested in studying responses to serious personal problems, it was important to construct questions that would influence respondents to think in terms of fairly high levels of distress. Based on the pretest data it became apparent that for black people the meaning of "nervous breakdown" was congruent with this goal. It was also felt, however, that only a minority of the sample would have ever experienced a personal problem so serious that it would elicit feelings of a "nervous breakdown." Therefore, the initial "nervous breakdown" item was followed by a series of questions ordered in decreasing levels of seriousness. These items form the basis of the Self-Reported Problem Severity variable.

Every respondent who indicated that they had experienced a serious personal problem (regardless of degree of self-reported severity) was asked to elaborate on what it was about. This item was referred to as Problem Type. For purposes of analysis, responses to this question have been categorized in five problem types: physical, interpersonal, emotional, death, and economic. Psychological distress was measured by using a 15-item symptom list. Each symptom endorsed by the respondent was further probed regarding a further subjective severity, by asking how often the respondent felt that way (i.e., lonely, depressed, jumpy). During the time the respondent was experiencing the personal problem, individual coping in response to the problem was assessed by asking each respondent if he or she had engaged in a list of behaviors to make the problem easier to bear. Finally, the use of informal and professional help was examined by presenting the respondent with a list of people or places a person might go to for help. The model of help-seeking that guided the data analysis was conceptualized as a decisionmaking process. Two of the decisions in this model are (1) decision to seek professional help in general, and (2) choice of a particular help source.

The majority of the sample, 63.6 percent (n=1,322), indicated that they had experienced a serious personal problem in their lives. Among the respondents who reported a problem, 47.3 percent experienced it at a nervous-breakdown level. In examining how this distress was labeled, we found that 41.5 percent of the respondents were upset because of an interpersonal problem, 21.6 percent experienced an economic difficulty, 16.2 percent experienced a physical health problem, 11.9 percent attributed their distress to having an emotional adjustment problem, and 8.9 percent were distressed because of the death of a loved one.

FACTORS RELATED TO REPORTED PSYCHOLOGICAL DISTRESS IN BLACK AMERICANS

One of the first set of analyses conducted on these data examined how demographic variables were related to distress as measured by the symptom checklist. As we indicated earlier, one of the advantages of having a large national sample is the ability to examine subgroup variation within the population in terms of reported mental health indices. In our multivariate analysis, we found that significant independent relationships to distress existed for education, employment status, and sex. Employed persons were significantly better off than unemployed persons, while increase in education led to a decrease in reported psychological distress. In keeping with other literature, men's distress scores were on the average 3.5 points lower than women's scores.

Our results indicate that the never-married individuals are a distinctive group. We found that the older, never-married individuals evidenced significantly higher levels of distress than younger never-marrieds. This is counter to the trend overall for all other marital status groups who showed decreasing distress with older age. The never-married group may be evidencing higher levels of distress because the lack of social support or existence of a close confidant, such as a spouse, may make them more vulnerable to distress. On the other hand, these never-married respondents may have always evidenced higher distress scores, even in younger years. These elevated scores might be indicative of some type of psychiatric disorder that made them less attractive as potential mates. The high rates of this group would not be detectable in the younger years, since they were counterbalanced by the group of young people who would eventually join the married group. Obviously, the selection argument is impossible to answer solely on the basis of cross-sectional data.

While income did not show any overall relationship to the general psychological distress measure previously described, an analysis of a subscale revealed a relationship between income, problem type, and psychological distress. Further exploration of this interaction indicated that income was negatively related to distress but only among respondents who had indicated an economic problem. While prior literature has indicated a negative relationship between socioeconomic status and distress, our findings suggest that this relationship only holds for economic problems. While this finding is intuitively obvious, that is, the poorer one is, the fewer economic resources one has available to respond to economic crisis, it also suggests that being poor may lead to the lack of other types of adequate coping resources.

In a further examination of coping with economic problems, our analyses revealed that over 55 percent of the respondents with family incomes of less than $10,000 said that their economic crisis brought them to a point of a nervous breakdown; this compares with 44 percent of those respondents making above $10,000. Examining employment status, we found that while 45 percent of the employed group experienced an economic problem at the nervous-breakdown level, a much larger proportion (58 percent) of the unemployed people did so. Finally, only 33 percent of men, but nearly 62 percent of women, said that their economic difficulties brought them to the point of a nervous breakdown.

Taking medicine and drinking liquor were rarely used as methods of coping with economic problems. Twenty-two percent of the unemployed, versus 11 percent of the employed, indicated taking medicine for their economic problems. Employment status was also related to drinking liquor, with the unemployed being more likely than those with jobs to engage in this type of behavior. Sex also showed a strong relationship to drinking. Only 16.5 percent of women drink liquor, and 39.4 percent of men did so. A substantial majority of respondents (75 percent) said that they tried to just relax in coping with their economic problems. Almost 70 percent tried to put the problem out of their mind, while 81 percent of the people with an economic problem tried to keep busy in order to deal with it. Only 14 percent felt that this was the most helpful thing they did. Finally, 80 percent of the respondents used prayer as a coping response. More importantly, 48 percent indicated that prayer was the one thing that helped them the most in dealing with their problem. The lower income group was more likely to use prayer than the upper income group. Women were more likely to pray than men.

Finally, we investigated how coping resources such as social support (operationalized as the number of informal helpers used in response to the problem) might work to ameliorate the deleterious effects of stress. In our analyses thus far, we have found no support for the hypotheses that network size serves as a buffer for the effects of self-reported problem severity on psychological distress. In fact, network size was found to be positively related to distress; the more informal helpers, the higher the distress score. One obvious explanation for these findings is that network size is not a very good measure of social support. In fact, we concluded that that relationship between network size and distress might best be understood within the help-seeking framework. Specifically, the more serious the problem, the more people within the network are consulted for help. While the more people consulted may not reduce the severity of the problem, it may indeed lead to seeking better or more appropriate types of professional assistance.

FACTORS RELATED TO THE USE OF INDIVIDUAL COPING STRATEGIES

Our first set of analyses focused in a descriptive manner on the variety of ways in which black people cope with stressful problems, particularly those that included seeking informal and professional help. One of the major findings of our study was that prayer was an important individual coping response. Forty-four percent of the respondents with a problem stated that this was the one thing they did which helped them the most. Twenty-five percent of the respondents stated that facing the problem squarely and doing something about it helped them the most. Another 13 percent indicated that keeping busy best helped them to cope, while 8 percent stated that they relaxed and took things as they came. Using medicine and drinking liquor, as we have indicated previously, were the least-often cited categories in general, receiving only 2.7 percent and 1.5 percent of the responses, respectively. Problem severity was significantly related to the individual coping strategy respondents felt was most helpful in making the problem easier to bear. The relationship between prayer, facing the problem, and problem severity was particularly noteworthy. As problems became more serious, the percentage of respondents that indicated prayer as the most helpful coping response increased. On the other hand, the percentage of respondents that indicated facing the problem squarely and doing something about it as the most helpful coping response decreased as problems became more serious.

There was also a significant relationship between type of problem and individual coping response. Prayer was the most often cited as a coping strategy utilized for all five types of problems ranging from 52.5 percent for physical health problems to 37.6 percent for interpersonal problems. Facing the problem was the second most frequent type of response given for all problem categories, ranging from 16.5 percent for death of a loved one to 29 percent for interpersonal problems. Copying was also significantly related to income, age, and sex. A higher percentage of those with family incomes under $10,000 saw prayer as most helpful. Of particular note were the relationships of age to prayer and facing the problem. The percentage of respondents stating that prayer was the most helpful was 32.2 percent in the youngest and 64.3 percent in the oldest groups. With respect to facing the problem, the percentages were 12.6 in the oldest group, 23.2 in the middle aged group and 32.2 in the youngest group. Finally, sex showed a significant relationship to coping, with more females than males, 50.7 percent versus 30.2 percent, reporting prayer as most helpful.

One of the most important findings of this preliminary set of analyses was the frequently reported use of prayer as the one most important thing done to make the problem easier to bear, even when problem severity and problem type were taken into account. This finding indicates just how important religion and the church are in the black community. These data provide preliminary support the well-known idea that prayer gives blacks, particularly the poor, women, and the elderly, a sense of strength with which to cope and to meet personal crises. We have also found in other analyses, not related to the present topic, that religion and the church are important general mechanisms for maintaining psychological well-being among blacks.

FACTORS RELATED TO BLACK HELP-SEEKING

The vast majority of our respondents (87.2 percent) sought help from at least one member of the informal network. While a little less than half (48.7 percent) sought some form of professional help. The combined pattern of informal and formal help-seeking indicated that 43 percent of the respondents who had a personal problem sought only informal help, 4 percent sought only professional help, 44 percent sought both informal and professional help, and 9 percent sought no help at all. A multivariate analysis of these four patterns of help-seeking showed that (1) women are more likely than men to seek both informal and professional help; (2) persons with physical health problems are more likely than persons with other types of problems to seek both forms of help; (3) respondents with emotional problems are more likely not to seek any help at all, either informal or formal; and (4) older respondents are less likely than younger respondents to seek formal help only.

Problem severity was not related to the use of informal help but was significantly related to the use of professional help. Of those indicating a nervous breakdown, 55.1 percent used professional help, while of those citing extreme nervousness, 37.7 percent sought professional assistance; 41.3 percent of respondents with problems such as depression utilized professional services, as did 50 percent of those with just a serious problem.

Type of problem was related to both the use of informal and professional help. Three patterns were notable in these relationships. First, a substantial majority of the respondents, between 75 percent and 91.1 percent, used informal help regardless of the type of problem. Second, emotional problems were the least likely to be taken to members of the informal network (75.2 percent). In comparison, 91 percent used the informal network for interpersonal problems, 90.4 percent in situations related to the death of a loved one, 89.3 percent for economic problems, and 87.6 percent in matters related to physical health. Third, use of professional help was most often reported for physical health problems (69.4 percent). Results also indicated that between 43 percent and 49 percent of the respondents used professionals for all other problem types as well.

We also explored how income, age, and gender related to professional and informal help-seeking. Our findings revealed that while the upper income group, that is those making $10,000 or more per year, were statistically more likely than the lower income group to seek help from friends and neighbors in response to personal problems, the percentage of difference was actually quite small 91 percent versus 85.5 percent). Income was not related to the use of professional help at all. Age on the other hand was significantly related to the use of both informal and professional help. The middle-aged group (ages 35 to 54) differed from the older group (age 55 and older) in using informal help, 89.8 percent versus 78.6, and from the younger group (ages 18 to 34) in using professional help sources, 83.1 percent versus 44.4 percent. Sex was also significantly related to the use of informal and professional help. With respect to the use of informal help, the percentage differences between men and women were quite small, 84.6 percent and 88.5 percent, respectively. In the use of professional help, however, as we have noted earlier, 51.7 percent of the women and only 42.2 percent of the men sought help.

In another set of analyses, we examined the use of specific professional help sources by type of personal problem. The highest percentage of users contacted private physicians (22.3 percent), ministers (18.9 percent), and hospitals (17.9 percent). No other response category was cited by more than 10 percent of the sample. Particularly noteworthy was the small number of individuals, approximately 3 percent, who reported seeking help at community mental health centers. Generally, our results indicate a very low usage of the mental health care sector. Only 9 percent of the respondents who sought professional help contacted a community mental health center, psychiatrist, or psychologist. Mental health care usage was low even among respondents who conceptualized their distress in emotional terms.

In contrast, the traditional health care sector, doctors, hospitals, and ministers were used much more often. Differences were also found among various subgroups within the black population. For example, there were no income differences in the use of physicians. This was true regardless of the type of problem or its perceived severity. On the other hand, low-income blacks were more likely than higher-income blacks to use public medical institutions, particularly hospital emergency rooms. This was especially true for interpersonal problems, where low-income blacks were overwhelmingly more likely than upper-income blacks to use this help source. We also found that low-income respondents were more likely to seek help from human service organizations, such as social services and community and private mental health centers, regardless of the level of problem severity or problem type. Finally, low-income respondents were significantly more likely to seek help from ministers for economic, emotional, and, especially, death problems.

Further analyses regarding hospital emergency room use indicated that 37 percent of blacks with family incomes under $5,000 used hospitals for help. This is in comparison with 28 percent of the $5,000 to $9,999 group, and 15 percent of the $10,000-and-above group. The poor were more likely to seek help from hospitals for interpersonal, economic, and, especially, emotional problems. Among respondents with interpersonal problems, 40 percent of those making less than $5,000 contact a hospital. This figure was 22 percent above the middle-income group and only 9 percent for the upper-income group. Thus, for the poor, hospitals and emergency rooms are a major resource for a broad range of problems, not just those that involve physical health.

In examining how gender related to help-seeking, while no sex difference in the use of hospitals was found, women were significantly more likely than men to contact private physicians regardless of the type and severity of the problem. Women were also more likely than men to use human service organizations. In fact, only 14 percent of the respondents who sought professional help contacted a social service agency to get assistance for their problems. Analyses revealed that low-income, low-educated, and older respondents were the most likely to use social service agencies. Persons with economic problems also displayed a high likelihood of social service use. In fact, further analyses revealed that low-income respondents were over twice as likely to use social services regardless of their education, age, gender, or problem type.

A major area of our interest in black help-seeking has been the nature and sources of referrals to the professional help network. All respondents who sought professional help were asked, "How did you first hear about that place as somewhere to go for help?" In analyzing the responses to this question, most people, nearly 53 percent, were self-referrals; 29 percent were referred by members of the informal network, which includes family and friends. Only 10 percent were referred by other professionals. An examination of the relationship between referral source and place of help, revealed that the majority of those who utilized hospitals, doctors and ministers were self-referrals. Among respondents who contacted social service agencies, community mental health centers, or private health therapists, most were referred by family members or friends. For community mental health centers and private mental health therapists, a substantial proportion of respondents were referred by medical professionals, usually doctors.

Further analyses revealed that 83 percent of those who contacted a hospital saw a physician, as did 94 percent of those who said they went to a private physician's office for help with their problem. Seventy-eight percent of the respondents who utilized social service agencies for help saw a social worker. The largest variation in type of professional helper contacted was in community mental health centers and private mental health therapists. For the former: 46 percent said they spoke with a psychiatrist, 18 percent mentioned psychologist, 18 percent cited doctor, and 14 percent said social worker. For mental health therapist: 33 percent said the person was a psychiatrist, 23 percent said social worker, 20 percent said psychologist, 15 percent said marriage counselor, and 8 percent said a regular physician.

All respondents who sought professional help were asked, "What did the person you saw do to try to help with your problem?" Overall the majority of respondents (60 percent) said that the helper took some specific action on their behalf. A little more than 14 percent of the respondents who sought professional help said that the practitioner just listened to them talk about their problem; 8 percent were referred to other professional helpers. For most of the places contacted the majority of respondents cited some specific action as the type of help received. This was true for hospitals, doctors, private mental health therapists, and social service agencies. For social service agencies, however, a sizable minority (24 percent) said that they were referred elsewhere. Among those who use community mental health centers, almost as many mentioned listening as a type of help (42 percent) as cited a specific action.

Ministers were the most distinctive help source as far as type of help was concerned; 31 percent of those respondents said that the minister listened, while 28 percent mentioned prayer as a type of help. In contrast with all the other help sources contacted, only 16 percent of the respondents who went to a minister received the type of help labeled as "specific action."

Finally, all the respondents who used professional help were asked if the helper they had seen was black. Forty percent acknowledged that they had seen a black practitioner. We examined race of helper by help source, however, and found that most of the respondents who saw a black professional (43 percent) contacted a minister. In fact, 88 percent of the ministers contacted were black; 17 percent of those who went to the doctor for help saw a black physician. For every other help source, less than 10 percent of the users stated they had seen a black helper.

We asked respondents who had not seen a black practitioner if they would have preferred to have seen one. Of the 373 people who did not see a black helper, only 21.5 percent stated that they would have wanted one. The percentage of respondents who would have preferred a black helper did not change substantially when help source was taken into account. Interestingly enough, preference for a black helper had no effect on responses to the question, "Would you go back to that place again if you needed help?" A substantial majority of respondents (87.7 percent) responded yes to this question. This was true regardless of the particular help source utilized.

SUMMARY AND CONCLUSIONS

Based upon the results of this national research we now know a great deal more about the nature of responses to serious personal problems in black Americans than was previously available in less systematic and representative studies. The problem-focused methodology used differed greatly from the majority of community-based survey studies of mental health previously conducted. Our concern was to gain information on the nature of and responses to a specific serious personal problem that caused a considerable amount of personal distress. We believe that the results of our analyses thus far support this approach to mental health community studies.

The majority of the respondents (63.6 percent) indicated having had a serious personal problem at one of the four levels of self-reported problem severity. We were then able to question them to ascertain how they responded to this problem in terms of their symptomatic reactions, severity of these reactions, individual coping strategies, informal helper used, and source of professional help employed, if any. The question of whether this procedure is a better one than the more traditional, diffuse system assessment used in previous community surveys is an empirical one that will have to be answered in future studies. It is also clear that this approach or some variant might be adaptable for use in studies that employ procedures for ascertaining more specific diagnostic categories.

We subsumed the discussion of our ongoing work under three broad rubrics: (1) factors related to the report of serious personal problems and distress, (2) factors related to individual coping reactions, and (3) factors related to informal and formal help-seeking. We have examined the nature of these relationships with multivariate analyses that permitted us to examine the independent and simultaneous effects of a number of potentially important factors. Thus, a number of socioeconomic indicators, such as income, that have been found in the literature to be related to distress, showed no effects when a number of other major demographic factors were controlled.

We were particularly interested in the extent to which the relationships between a given demographic characteristic in distress varied according to the nature of the problems experienced. Thus, income, which showed no overall relationship with distress, was related among respondents with economic problems; these economic problems created greater psychological distress in poorer respondents. Another example presented indicated that the general tendency for women to experience greater distress than men did not apply to problems precipitated by the loss of a loved one--the devastating impact of such experiences was greater for our male respondents. Findings such as these illustrate one of the values of the large representative sample obtained in our study and enables us to explore the heterogeneity of the black population and to specify the complex problems and patterns of responses in different subgroups.

Another set of findings discussed related to the way that black Americans cope with the problems they experienced, particularly their use of informal and formal help. In studying coping we have been especially interested in the use of prayer. The major research literature on coping has neglected the adjustment role of prayer in the black community. Its importance is illustrated both by the large number of respondents who placed major reliance on prayer in attempting to deal with their problems and in the finding that the use of prayer increased with the severity of the problem experienced. Our analyses also helped pinpoint the subgroups where prayer was particularly important, women, the poor, and the elderly.

In our analyses of help-seeking, one focus has been the relationship between the use of informal and formal resources. In discussions of the help-seeking process in minority populations (particularly when the author is speculating that minorities in need of help are underutilizing mental health resources) the assumption is often made that minority members are rejecting formal institutional resources and relying on family, kin, and friends instead. Our data do not support this assumption. Formal and informal resources are not mutually exclusive alternatives. Rather, there is a positive relationship between the use of formal and informal resources. The greater the number of informal helpers invoked during a specific problem episode, the greater the likelihood that the help-seeker will also use professional help. Almost all the respondents in our study who mentioned experiencing a severe personal problem turned to a friend or family member with that problem, and half of them also turned to a professional resource for help. Only rarely did a person use a professional helper without also having relied on informal help.

In a series of multivariate analyses of factors related to the use of informal and formal help, we found some differentiated relationships. For example, problem severity was related to the use of professional help but not to the use of informal resources (although severity was related to the number of informal resources used). In general, factors related to one type of resource were also related to the other. Women tended to use both types of resources more than men; middle-aged individuals were more likely than other age groups to use both types. Income had no relationship to the use of either formal or informal help. In analyzing the determinants of the help-seeking process, we found the critical issues to be what factors effect the readiness to turn to any resource for help, either formal or informal, not what distinguishes those individuals that use one type of help over the other.

Much more differentiation was evident from analyses of the determinants of the types of formal resources utilized. In analyses paralleling those used in the exploration of the determinants of distress, differences were found between those who turned to physicians, human service organizations, and private mental health therapists. These differences varied depending on the nature of the problem. For example, there were no bivariate relationships between sex and the use of private mental health therapists. But when this relationship was viewed separately by problem type, women were much more likely to use therapists for interpersonal problems, while men were more likely to use therapists when suffering from the death of a loved one.

Our general results revealed that factors such as income, age, and marital status have more complex relationships than suggested in previous studies. Similarly the observed sex effects suggest slightly different relationships than those reported in prior studies. Analyses of the informal network indicate the crucial role that it may play in alleviating distress while simultaneously serving as a major conduit to professional treatment.

Professional treatment and the manner of entry was also found to be highly complex. Income does not show a general relationship but is conditional upon the nature of the problem. Similarly, sex effects are dependent upon the severity of the problem. Other complex relationships are also found for age. Different age groups appear to use different types of professional services depending upon the nature of the problem. The importance of ministers in alleviating personal distress was also clearly indicated by our findings. Finally, somewhat surprisingly, race of the professional helper does not appear to have a large effect on subjective evaluations of the effectiveness of help or willingness of blacks to use professional facilities in the future.

This summary of the major findings indicates the complexity of the relationships that exist among factors related to experiencing serious personal problems, symptomatic reactions, and help-seeking among black Americans. The size of the sample and nature of substantive information has permitted us to go beyond previous studies that have utilized smaller and less-representative samples of black.

IMPLICATIONS FOR MENTAL HEALTH SERVICE DELIVERY AND TRAINING

The results reported here have clear implications for the training of mental health professionals and the delivery of mental health services to black Americans. First, it is evident that black Americans are willing to use professional services for self-defined mental health problems. While professional help sources in our study ranged from ministers to traditional psychiatrists and psychologists, they were sought out as sources of help, particularly if referred by the informal network. Thus, our findings suggest that the informal network of friends and relatives does not serve as a substitute for professional help, but instead may be an important conduit and contact into the professional health network. While a great deal is written about the training of professionals to utilize family and friends, our findings suggest that such training is critical if people are to be appropriately referred.

Another major conclusion that can be drawn from our work is the importance of religion and the church as sources of mental health service delivery and as individual coping resources. The overwhelmingly large number of respondents who report using either prayer and/or seeking contact with ministers for significant and serious personal problems cannot be lightly dismissed. Most progressive mental health professional training has acknowledged the need for community outreach and contact with traditional institutions within minority communities. The findings from our research suggest that this is a critical dimension in the delivery of mental health services. A particularly disturbing finding is the low proportion of individuals who report being referred by other professionals. Since the majority of contact is with ministers, one implication of this finding is the need to train mental health professionals to make contact with major religious institutions in the black community. Such training and consultation may be critical in getting blacks who suffer from significant mental health problems into the professional health delivery system. In order to use these major institutions within the black community, some understanding of their history and function must be understood by mental health professionals. One of the major problems that often occurs in health and mental health training is an active avoidance of these types of community institutions. While the more enlightened mental health professionals will idiosyncratically utilize such resources, it has not been a major part of the training curriculum. However, some notable exceptions do exist (Lefley 1982, Weidman 1982).

As indicated in the beginning of this chapter, a major aspect of the problem in mental health service delivery and training of practitioners for work in ethnic minority communities resides in the lack of knowledge regarding the mental health status and utilization patterns of black Americans. The results of our study can be important in providing information about the nature of mental health problems and preferred modes of mental health utilization within the black community. Thus, the first objective would be to have such data included as part of mental health training at all professional levels. At a minimum, cultural competence includes an understanding and acceptance of the peculiar cultural forms of the racial/ethnic group in question. For example, our findings regarding the use of black or white mental health professionals indicate less preference for same-race professionals than we had expected. While 21.5 percent is a sizable proportion, nearly 80 percent of our respondents who had cross-race contact indicated no necessary desire to see a black professional. This suggests strongly that the mere race of the mental health worker is not necessarily relevant to blacks seeking help for serious personal problems. It argues even more strongly for the inclusion of cultural training and understanding within the general framework of mental health professional training and curriculum.

We believe that the findings of our study and similar studies could be included as a regular part of the materials used in the training of mental health professionals. In addition, our findings related to prayer and the utilization of the church and ministers as important help resources indicate the existence of important cultural dimensions that should be emphasized in such training. There are several questions, however, that are left unanswered by the research that we have done so far. Some of these issues can be addressed with further work in our current dataset, and others demand additional major data collections as well as major longitudinal and panel studies. For example, low-utilization rates for community mental health centers suggest the existence of real or perceived barriers in these institutions. What is the nature of these barriers? How can they be overcome? Should they be overcome? How does the use of informal and formal mental health resources relate to the quality of care? What are the appropriate treatment modalities for black Americans? How can they be adequately assessed beyond self-reports of satisfaction? How do sociostructural conditions and changes in such conditions affect the assimilation of blacks into mainstream Anglo culture? How will this affect the peculiar nature of the current cultural differences between Anglos and blacks, and what implications will this have for changes in the training and nature of health service provision? Will this mean cohort or generational differences in the nature of types of services provided.

What is the relationship between poverty and other socioeconomic indicators and the utilization of mental health services? Our research has only scratched the surface of this topic. How are changes in current insurance plans related to the availability of mental health services? Particularly important are such things as DRGs and the growth of for-profit hospitals and clinics in relationship to the delivery of services to racial/ethnic minority community populations. We are currently investigating how barriers such as the availability of insurance or geographical location may relate to the use of services (Neighbors and Jackson 1986).

Our primary focus in this research on black mental health has been with individual reactions to circumstances and situations. As indicated earlier systemic conditions are important in understanding and interpreting these individual reactions. In the survey we attempted to obtain subjective estimates of the nature and extent of these structural impediments. While the understanding of culturally determined forms of behavior is important in mental health professional training and service delivery, it must not be forgotten that these cultural behaviors, values, and mores are enmeshed in a larger system of sociostructural conditions that have direct and important mediating effects on ethnic/racial communities, families, and individuals.

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CHAPTER 5

MAKING EFFECTIVE USE OF RESEARCH TO IMPACT THE TRAINING OF CULTURALLY SENSITIVE MENTAL HEALTH WORKERS

J. Manuel Casas, Ph.D.

Over the years, the professional literature has repeatedly expressed its concern that the field of counseling psychology is falling short of meeting the mental health needs of racial/ethnic minorities, that is, blacks, Hispanics, Asian-Americans, and Native Americans (e.g., Bernal 1980, Padilla and Ruiz 1973). Given the frequency with which this concern has been expressed, one might expect that major and concerted efforts by mental health professionals have been taken to ensure that the mental health needs of racial/ethnic minorities were adequately met. In selected instances, this has proven to be true. For instance, the major professional organizations such as the American Psychological Association (APA) and the American Association for Counseling and Development (AACD) set up special boards and commitees that were charged with the task of developing resolutions and recommendations to more effectively meet the growing mental health needs of racial/ethnic minorities. (For a detailed and historical overview of the actions taken by the respective organizations, see Casas 1984.)

Owing to the widely acknowledged link that exists between the breadth and quality of training provided to preprofessionals and the subsequent quality of treatment that these professionals can provide to their clients, most of the resolutions and recommendations directly and/or indirectly addressed the area of training. In addressing this area, the tendency was to approach it from two general perspectives. While one strongly focused on the actions that could be taken to increase the number of racial/ethnic minority persons in the counseling psychology profession, the other addressed the need to develop training programs that would pay greater attention to the increasing racial/ethnic diversity in the society by incorporating those aspects of psychology that pertain to culture and race/ethnicity.

With respect to the number of racial/ethnic minority counselors, there is some evidence that the efforts to increase the number of minority mental health workers, at least within the broad field of psychology, have paid off. More specifically, there are data that show an increase in the percentage of racial/ethnic minority psychology doctoral recipients (Russo et al. 1981).

However, racial/ethnic minorities continue to be severely under-represented in training programs and researchers such as Bernal further contend that the incremental trends appear to be so weak that they are almost meaningless, given the mental health needs of rapidly growing racial/ethnic minority groups. Bernal (1980) believes that the total number of current graduate students and the rate at which they are completing their training are so low that it will be impossible to meet the vast mental health needs of racial/ethnic minority groups at any time within the next 5 to 6 years.

With respect to training, professional organizations have also taken steps to make training program curricula more responsive to racial/ethnic minority needs. These efforts are well exemplified in the work of the Counseling Psychology Division of APA. This Division recommended that training programs pay greater attention to the increasing racial/ethnic diversity found in our society. In fact, this Division took a strong and very directive position relative to cross-cultural counseling by putting forth a position paper that recommended the adoption of specific cross-cultural counseling and therapy competencies that could be used as criteria for the accreditation of training programs (Sue et al. 1982).

Wishing to expedite and/or facilitate the attainment of recommendations such as those put forth in the position paper mentioned above, a good number of authors published articles in the professional journals and put forth conceptual frameworks for integrating racial/ethnic minority curricula and practica in existing training programs (e.g., Bernal et al. 1982). Furthermore, on a national scale, several conferences and workshops were organized by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) to address the training of mental health professionals. More recently, a major effort to develop a minority curriculum was undertaken at Howard University (Chunn and Dunston 1980), with funding from the National Institute of Mental Health (NIMH).

Unfortunately, while there are data to gauge the success of efforts to increase the number of racial/ethnic minority health professionals, there lack complementary data to assess the success of efforts to revamp training programs. Addressing this situation, Bernal and Padilla (1982) recently conducted a survey to determine the current status of minority curricula and training in clinical psychology. Their survey collected data on coursework, practicum, and research training that might prepare the clinical psychologist to work with racial/ethnic minorities. Findings largely reflected a reluctance by organizers of training programs to include coursework on mental health and sociocultural issues relative to minority groups. Furthermore, although the findings indicated that the preparation of clinical psychologists to work with minorities is regarded as "somewhat important," they also provided ample evidence that such preparation actually receives minor attention. With respect to coursework (Bernal and Padilla 1982, p. 785),

> the most striking finding was that, although many minority-related courses were being taught in a relatively small number of programs, the majority of programs offered no course that emphasized sociocultural variables in understanding human behavior. Only two programs offered courses on minority children, despite NIMH's identification of minorities and children as major underserved populations. Only a handful of programs required a sociocultural course for the Ph.D. degree.

In a recently completed study, Ponce et al. (1985) surveyed 91 counselors working in a variety of mental health settings and found that less than one-third of the respondents reported getting any type of training that directed attention to racial/ethnic minority issues.

Because of the changing demographics of racial/ethnic minorities, the mental health profession can ill afford to continue echoing its concern for the mental health needs of racial/ethnic minorities. At this time, the changing demographics require that the expressed concern be backed up by actions that can bring about all the necessary changes within training. To appreciate the need for action, one need only to consider the following statistics. While the total U.S. population is increasing, the racial/ethnic minority population is increasing at a much faster rate than the population designated by Census reports as white. Furthermore, as a result of the youthfulness of racial/ethnic minorities, prevailing high fertility rates, and continued immigration from such areas as Mexico, Central America, and Southeast Asia, it is expected that the racial/ethnic minority population will continue to increase at an accelerated rate, especially in large metropolitan areas. Addressing these statistics from a mental health perspective and taking into consideration that research provides evidence of continued racism and discrimination in complex forms (e.g., Crosby et al. 1980, Sears et al. 1977), one could probably expect that persons from racial/ethnic minority groups will continue to suffer disproportionately--as they have in the past--from the alienation and fear and depression and anger that accompany prejudice, discrimination, and poverty (President's Commission on Mental Health 1978). Thus, it is quite likely that they will need more mental health care, possibly in a language other than English, and presented competently in a culturally sensitive manner (Bernal and Padilla 1982).

Through this paper, I wish to stimulate and/or facilitate the type of action that is urgently needed by exemplifying a particular way through which training programs can easily become more responsive to the mental health needs of racial/ethnic minorities. More specifically, this paper shows the manner by which relevant research findings can be integrated into counseling psychology training curricula to enhance the sensitivity of counseling psychologists toward racial/ethnic minority clients. To attain this goal, the paper (1) identifies the generic characteristics or competencies that training programs should seek to develop in culturally sensitive counselors, (2) reviews selective research findings that have the potential for use in developing these characteristics, (3) suggests ways that such findings can be incorporated into the training curricula, (4) examines the mechanism that training programs can develop to assess cultural sensitivity in counseling trainees, and (5) makes recommendations regarding the direction that both research and professional policy should take to ensure an increase in the number of programs that train culturally sensitive counselors.

A PROFILE OF THE CULTURALLY SENSITIVE COUNSELOR

For training programs to adequately prepare counselors who can sensitively and effectively address the mental health needs of racial/ethnic minorities, it is necessary that programs first identify the characteristics and/or competencies that such counselors must acquire. Fortunately enough, over time a variety of profiles depicting the culturally sensitive counselor have been developed (e.g., Pedersen 1978, Sue 1977). One profile that merits attention because of its comprehensiveness was put forth by the Education and Training Committee of the Division of Counseling Psychology of the American Psychological Association (Sue et al. 1982).

The profile presented by this Committee addresses from three distinct perspectives those characteristics/competencies that a culturally sensitive counselor must have: attitudes, knowledge, and skills. Pragmatically, the reason for addressing these three perspectives is based on extensive empirical evidence that demonstrates the important role that attitudes, knowledge, and skills play in the counseling process per se (Ivey and Authier 1978). Philosophically, addressing these three perspectives is rooted in the belief that the counseling profession has the moral and ethical responsibility to obtain an accurate and sensitive understanding of the unique needs of individuals from racial/

ethnic minority groups as well as to identify and develop those counseling skills that are most appropriate and effective with racial/ethnic minority persons (Casas 1984).

An overview of the profile developed by the previously mentioned APA committee and the specific characteristics/competencies attached to each perspective are presented here. In addition, some of the author's ideas are also included.

From an attitudinal perspective, training programs should seek to develop counseling psychologists who are (1) aware and sensitive to their own cultural heritage; (2) able to value and respect cultural differences; (3) aware of their own values, biases, and stereotypes and the impact that these can have on their interaction with and/or overall treatment provided to racial/ethnic minority clients; (4) accepting of and comfortable with any differences that may exist and/or arise between themselves and their clients, such as ethnicity, race, beliefs, attitudes, values, life styles; and (5) sensitive to circumstances (e.g., personal biases, stage of racial/ethnic identity, sociopolitical influences) that may dictate referral of racial/ethnic minority clients to professionals from their respective racial/ethnic groups.

From the perspective of content and knowledge, the task of training programs should be to instill in counseling trainees (1) a good historical understanding of the sociological, political, and economic treatment of racial/ethnic minority groups in the United States; (2) specific knowledge and information about the characteristics attributed to these groups (e.g., world views, family dynamics, perceptions of mental health); (3) an understanding of the cultural, social, and/or economic variables that may account for the characteristics attributed to these groups; and (4) an understanding of the link between sociopolitical, and economic status of racial/ethnic minorities and their susceptibility to specific mental health related problems (e.g., stress, hypertension alcoholism, and suicide).

So that preprofessional counselors can directly tie knowledge to counseling itself, counseling trainees should acquire (1) a solid understanding of counseling theories and philosophies; (2) an understanding of the generic characteristics of counseling; (3) an awareness of any factors that might limit the utility of existing counseling theories and approaches with any or all racial/ethnic minority groups; and (4) knowledge of environmental, social, and institutional barriers that may limit racial/ethnic minorities from making effective use of mental health services.

Finally, in terms of skills, counseling trainees should be prepared to (1) send and receive both verbal and nonverbal messages accurately and appropriately; (2) assess and, in turn, understand the presenting problems from multifactored perspectives that take into consideration both intraperson and extraperson variables; (3) develop effective therapeutic interventions that are socioculturally sensitive and that expediently address the "real" problem; and (4) exercise institutional intervention skills on behalf of racial/ethnic minority clients when necessary.

ASSESSING AND MAKING USE OF AVAILABLE TEACHING MATERIALS: RESEARCH ARTICLES

Having access to profiles such as that detailed in the preceding section should facilitate the efforts of programs that seriously seek to train culturally sensitive counselors. The major task that such programs must undertake is that of identifying and/or developing curriculum material and effective teaching procedures and techniques. Undertaking this task need not be overwhelming nor time exhausting. Essentially, the type of materials needed are available. The last few years have witnessed quite an increase in books (e.g., Atkinson et al. 1979, Pedersen et al. 1980) and research articles in professional journals that provide content material suitable for the development of new courses that focus directly on racial/ethnic minority groups and/or for easy incorporation into existing core counseling courses.

To illustrate the feasibility of accessing and making effective use of available materials, several research articles written by this author are used here to illustrate how research articles can be used as the basis for new courses, integrated into existing curricula, and/or used as the stimulus for experiential learning activities.

Let us focus first on attitudes and beliefs. Two related analogue studies address the impact that the tendency to stereotype can have on the accurate processing of information by preprofessional and professional counselors working with racial/ethnic minorities. The first study entitled "The Categorization of Ethnic Stereotypes by University Counselors" (Casas et al. 1981) sought to identify the cognitive organization used by a specific group of counselors working at a large West Coast university to process information about students. More specifically, this study explored whether stereotypes commonly associated with specific racial/ethnic groups (i.e., Anglo, Chicano, and Asian-American) would automatically be categorized together. To this end, each of 30 stereotypic characteristics commonly attributed to each of the three target racial/ethnic groups (10 per group) was printed on an index card. The counselors were in turn requested to sort the cards into piles so that each pile contained cards that could be used to characterize a single student; that is, each pile would represent a hypothetical student. The counselors were allowed to make as many or as few piles as they felt appropriate, and they were not informed that the characteristics represented ethnic stereotypes. The results from this study clearly indicated that the counselors used organizational strategies in such a way that stereotypes for each racial/ethnic group were categorized together in constellations, although there was a tendency not to differentiate between Anglo- and Asian-American stereotypes.

If the results of this analogue study are generalizable to counselors in the field, then it well may be that the effects of stereotyping may be more detrimental than might be expected. The results suggest that counselors have a constellation of stereotypes for each racial/ethnic group; the confirmation of one stereotype in this constellation probably will tend to confirm the entire constellation. Because stereotypes have been shown to affect how counselors process additional information about racial/ethnic groups (Wampold et al. 1981), they may actually prevent the access of the very information needed to reject incorrect stereotypes.

The objective of the second study, which complemented the first study and is entitled "Ethnic Bias in Counseling: An Information Processing Approach" (Wampold et al. 1981), was to determine how preexisting ethnic stereotypes affect the processing of information about clients by mental health professionals. Specifically, an illusory correlation (Chapman 1967, Chapman and Chapman 1969, Hamilton 1976) paradigm was used to assess how stereotyping by counselors in training interferes with making correct judgments about the relationship between an individual's ethnicity and the individual's characteristics. To attain desired objectives researchers presented two subject populations, Anglo-American and ethnic-minority graduate students in counseling psychology, with the following information about hypothetical persons: (1) stereotypic characteristics, (2) ethnicity, and (3) blood type (a neutral stimulus). The students were then asked to make judgments, based on the data presented to them, about the relationship between ethnicity and stereotypic characteristics as well as between blood type and stereotypic characteristics. While both subject populations made nearly the same number of errors on the ethnicity items as on blood type items, the Anglo-American group made fewer on those items for which a stereotypic response was incorrect, indicating that stereotyping did affect the processing of information relative to ethnicity. Interestingly enough, this phenomenon was not present for the ethnic minority group.

From the results obtained in the second study, it is apparent that stereotyping can interfere with the processing of information about members of various ethnic groups. The full impact of this bias can only be surmised; however, one effect may be the well-documented differential diagnosis and treatment that racial/ethnic minorities receive when they use mental health services (e.g., Bloombaum et al. 1968).

The findings from these two studies and those obtained by other researchers (e.g., Bloombaum et al. 1968) clearly demonstrate the deleterious effects that an ingrained tendency of counselors to stereotype can have on the provision of services to racial/ethnic minorities. Apparently when it comes to working with persons from other cultures, traditional counseling core courses that focus solely on listening, information-gathering, and decisionmaking skills are just not enough. To make effective use of these skills with persons from other cultures, the counselor in training must understand the "mind set" that determines what is actually "heard" and that in turn sets the direction for the therapeutic process. If one works from this perspective, it seems imperative that training programs acknowledge the importance of these studies and in turn make comprehensive use of them to help counselors-in-training acquire the additional skills necessary to avoid the deleterious effects of stereotyping. To this end, experimental materials similar to those used in the present study could be employed as selection and training materials to measure individual bias, to help students become cognizant of their biases, and to serve as a stimulus for discussion of information processing vis a vis stereotypes. Ideally the experimental materials and the studies themselves could be used within a designated counseling core course(s) that directed attention to the varied factors that affect interperson and intraperson information processing. The effectiveness of these courses can be maximized by including in the curricula, life experiences that would help counselor trainees develop both a cognitive and affective sensitivity to the effects that their stereotypes, no matter how subtle, may have on racial/ethnic minority clients.

As a basis for discussing the area of knowledge, an overview of findings from an extensive NIMH-funded project, which comprised many substudies, is provided here. The general objective of the project entitled "Social Interactional Strengths of Mexican-American Families" (Casas et al. 1984) was to provide information on the Mexican-American family, an entity on whom very little accurate and empirical information is available (for details on this phenomenon, see Keefe and Casas 1980). A particular aim of the project was to identify specific familial behaviors prevalent in the Mexican-American social culture that are associated with the

Mexican-American child successfully functioning in school. Starting with the assumption that interaction in the family is a primary source of sociocultural effects on children, we sought to assess the relationships between Mexican-American children's interactional/socialization experiences (e.g., parental teaching styles, disciplinary practices) and various measures of cognitive and school performance. Finally, focusing on the intragroup variability that exists among Mexican Americans, we attempted to identify differing patterns of interaction/socialization practices between Mexican-born and U.S.-born Mexican-American parents (e.g., decisionmaking practices and distribution of household duties).

The sample for the study consisted of 65 families that met the following criteria: (1) that they have at least one child in the lower elementary school grades; (2) that the family be intact, with both parents willing to participate in the study; and (3) that the primary supporter of the household be a blue-collar worker. In half of the families both parents were born in Mexico; in the other half one or both were born in the United States of Mexican parentage. Furthermore, the children were divided equally between boys and girls. Half were 5 to 6 years of age, and half were 7 to 8 years old.

To obtain the desired information, the husbands and wives were individually interviewed five times and interviewed as a couple once. In addition, during one of the individual interviews, the husbands and wives were observed teaching the target child a standardized activity.

Though varied findings are emanating from the substudies of the project, it is impossible because of the constraints of this paper, to list them all. However, from a general perspective, suffice it to say that the following results, which were found across all substudies, will help dispel unfounded stereotypes and beliefs about the Mexican-American family: (1) There is a great variability across a variety of social and psychological factors within the Mexican-American populace; (2) a significant amount of the variability found in this populace results from level of education and length of time in the United States; and (3) families with children who do well cognitively and academically tend to be more educated and fit more into a white/middle class profile.

In the past the tendency of training programs was to use anecdotal and descriptive materials that were easily available but that provided very simplistic and, most often, inaccurate information on racial/ethnic minority groups. If culturally sensitive counselors are to be trained, this tendency must cease. Instead, programs must avail themselves of empirical information provided by projects similar to the one described here. Such information could be used as the basis for new training courses that focus directly on the important and unique social and psychological factors that may be inherent in any or all racial/ethnic minority groups. If the creation of new courses is not possible, the information could be easily integrated into those that already exist. For instance, recent findings on racial/ethnic minority families (e.g., decisionmaking patterns and gender roles) could become a special unit in standard marriage and family courses.

As a basis for discussing the skills perspective, attention is directed to a study entitled "Stress and Coping Among University Counselors: A Minority Perspective" (Casas et al. 1980). One of the major objectives of this study was to identify potential sources of stress encountered by racial/ethnic minority counselors as they carry out their professional responsibilities in institutions of higher education with predominantly Anglo students, teachers, and staff. Pursuant to this objective, a questionnaire was mailed to university and college racial/ethnic minority counselors asking them to identify the types of on-the-job stress they encounter and the availability of self-help networks and/or other coping mechanisms used to cope with such stressors. A major finding concerned the type of on-the-job stressors experienced; a significant number of respondents identified the personal expectations placed on them by the university and the minority community, the lack of sensitivity of nonminority personnel, and the lack of institutional support for the role of "minority counselor" as primary sources of stress. An equally important finding was that another large group of respondents also reported more similarity in their role definition between themselves and their clients (e.g., change agent) than between themselves and their supervisors (e.g., change agent vs. therapist).

The findings from this study that indirectly touch on skills development have interesting implications for the training of culturally sensitive counselors and, in this case, racial/ethnic minority counselors per se. For instance, the fact that racial/ethnic minority counselors may experience unique stressors should serve as the impetus for training programs to provide preprofessional and in-service units that will sensitize counselors and counselor administrators to important psychosocial variables that may be correlated with race ethnicity and that must be considered in communicating with or providing services to other cultures. Also, the findings should encourage training programs to seek to accurately understand the racial/ethnic minority counselor's role in predominantly Anglo institutions and to identify the unique training and responsibilities that are inherent in the role so that the discrepancy in job responsibilities that this study shows to exist between supervisors and many racial/ethnic minority counselors may be prevented. In other words, if racial/ethnic minority counselors are expected to be change-agents, ombudsmen, and community liaisons in addition to being therapists, then relevant training needs to be developed and provided.

ASSESSING THE CULTURALLY SENSITIVE COUNSELOR

The mechanisms for individually or dually assessing knowledge and skills are much easier to access or develop than those for assessing attitudes. For instance, to assess knowledge, objective tests are available or could be easily developed that would reflect specific topics and issues covered in courses and units on racial/ethnic minorities (e.g., historical information, recent findings reported on the family, or the sociopolitical and economic factors that impact racial/ethnic minorities). In turn, skills could be assessed through the use of role-playing, video taping of counseling sessions, in vivo observations of counseling activities, and/or structured supervision/evaluation in community settings by master counselors selected on the basis of their level of cultural sensitivity.

In the near future three paper-and-pencil measures being developed and tested by Pedersen (personal communication, March 1985) may facilitate the assessment of both skills and knowledge. The first measure presents a series of short and specific therapeutically related incidents and/or situations and asks the respondent to identify the nature of the presenting problem (i.e., interpersonal, intercultural, or psychopathological); the second seeks to identify the trainee's knowledge about the attitudes of racial/ethnic minorities toward specific life experiences (e.g., suffering and pain, mental health treatment, child-bearing, or authority); and the third focuses on the cultural accuracy and therapeutic appropriateness of counseling responses that could be made to individual racial/ethnic minority clients presenting specific problems and concerns.

The assessment of attitudes, in turn, is not as straightforward as in the assessment of knowledge and skills. First of all, given the complex nature of measuring attitudes, relevant materials are not as accessible. Furthermore, with respect to procedures, in assessing attitudes it is important that preassessments be conducted to make the counseling trainees aware of their attitudes (i.e., beliefs, biases, or stereotypes). The information obtained from this preassessment should then be used to select and/or develop appropriate educational materials. The actual assessment tools that could be used for the preassessment and postassessment could be paper-and-pencil measures such as those used in research studies by Bloombaum, et al. (1968), and/or techniques such as those used in the two stereotyping studies described above.

A future approach that might lend itself to assessing attitudes, knowledge, and skills simultaneously could involve the development and use of computer software that puts the trainee in simulated counseling interactions. In these interactions the trainee would be presented with varied issues and/or problems and be asked to identify specific solutions. The choice of solutions would reflect a personal, cultural, or institutional orientation. With the use of all of the trainee responses, the program would then provide a profile of the trainee's strengths and limitations with respect to attitudes, knowledge, and/or skills.

CONCLUSION AND RECOMMENDATIONS

As stated earlier in this paper, the counseling psychology profession continues to fall short in effectively understanding and meeting the mental health needs of racial/ethnic minorities. Therefore, the goal of this paper was to demonstrate the manner by which readily available materials, in this case, research articles, could be effectively used by counseling psychology training programs to enhance the sensitivity of counseling psychologists toward racial/ethnic minority clients.

Although such demonstrations are not new, from the available data it is apparent that they are still greatly needed to underscore the fact that making training programs responsive to the needs of racial/ethnic minorities is not an overwhelming objective. On the contrary, it is an objective that is easily within reach of any training program that is motivated to work towards its attainment.

Working from this perspective, this author contends that the present task of the counseling psychology profession is not to provide further demonstrations but to identify and implement incentives that will provoke training programs to take relevant actions. To this end, the following recommendations are put forth:

1. Accreditations of training programs should be contingent on (a) demonstrated efforts to recruit, admit, and retain racial/ethnic minority students and faculty; (b) the provision of racial/ethnic minority curricula and training; and (c) the review and approval of course content and training procedures by an informed and sensitive office or committee (e.g., the APA's Office of Minority Affairs).

2. Funding agencies (e.g., NIMH) should make eligibility for awards by institutions contingent on meeting the same criteria as that suggested for accreditation.

3. Preparation for licensing should require coursework pertinent to racial/ethnic minority persons. Such coursework should emphasize sociocultural variables in understanding human behavior. The licensing exams should contain a significant amount of relevant questions dealing with racial/ethnic minority groups and concerns.

4. As with individuals who specialize in the use of special techniques (e.g., hypnotherapists, sex therapists), certification should also be required of any individual whose position requires extensive interactions with persons from racial/ethnic minority groups.

As evident, these recommendations are quite direct; yet given the past record of the counseling psychology profession relative to racial/ethnic minorities, they represent the type of recommendations that must be promoted and acted upon at this time. After all, when all is said and done, there is no question that the profession knows what it ethically should do and knows how to do it. All that is necessary is for counselors to want to improve their delivery of mental health services to minorities.

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CHAPTER 6

HISPANIC HUMAN RESOURCE ISSUES: A REASSESSMENT OF MENTAL HEALTH MANPOWER NEEDS

Roberto Quiroz

Extensive reviews, findings, research studies, and symposiums have addressed the issue of ethnic minority human resource development and training designed to strengthen the relevancy and appropriateness of mental health service to ethnic minority communities throughout the country.

The implied premise of many of these efforts has been that not only do ethnic minority communities require different kinds of intervention strategies and techniques to ensure accessibility of services, but also that there is something unique or different in the treatment methodology, mode of service, or therapeutic process in working with ethnic minorities. The result of this approach has been to relate ethnic manpower development to a qualitative difference in the kinds of treatment services that would be most effective with an ethnic minority population. As a result, ethnic minority professionals within academic and practice settings have continually carried the "burden of proof" for stimulating and motivating institutions providing services that are accessible and culturally relevant.

The issue of reallocation of resources and services in a manner equitable and proportionate to the characteristics of the population in a catchment area has often been tied to the issue of demonstrating "unique and specialized" treatment methodology approaches that would justify continued funding or a greater allocation of resources.

From staff of large academic institutions to those in comprehensive community-based mental health programs, who represent perhaps 1 to 5 percent of that program's total funding resources, all have shared the common experience of "burden of proof" in motivating their organization to reallocate resources to enhance accessibility of services to ethnic minority populations. Clearly, we need to define the issues and underlying premises inherent in the development and training of ethnic minority resources to fill current service needs and requirements in our mental health delivery system within the next decade. Some of those issues are:

1. To review mental health manpower needs in general as the focus of public resources shifts to treating a more severely and chronically disturbed population.

2. To recruit and hire ethnic minority personnel who would deliver culturally and linguistically appropriate services.

3. To augment ethnic minority human resources capability as a "personnel affirmative action issue," which is an end in itself.

4. To distinguish between service delivery strategies and techniques of intervention and therapeutic processes/treatment modalities.

We must raise the issue of mental health manpower needs in general as the focus of public resources shifts to treating a more severely and chronically disturbed population.

The deinstitutionalization movement has greatly affected community-based service delivery systems, particularly in working with the more severely and chronically distressed populations, who experience a high rate of recidivism in the absence of meaningful support systems and alternative community programs. In addition, the passage of the Lanterman-Petris-Short Act in California in 1969, while ensuring the protection of the basic rights of the client, has inadvertently made it difficult to provide appropriate and sustained long-term treatment for individuals who do not meet the basic criteria for involuntary hospitalization. These people are not considered suicidal, homicidal, or gravely disabled, but nonetheless they require some form of care and are unwilling to seek or receive such care voluntarily.

Thus, current commitment laws and philosophical adherence to the concept of deinstitutionalization within a framework of services lacking viable community alternatives are often cited as primary causes of the growing number of homeless mentally ill, whose plight has focused national and local attention on the mental health service delivery system.

While most agree that the resources simply have not followed the patient from the hospital to the community, it is also increasingly apparent that our current service delivery system is ill-equipped to meet the needs of a severely and chronically disturbed population. We have been unable to examine critically our current structure of services, staffing patterns, and capabilities. We must make the necessary decisions and reallocate resources to develop the case management and support services so sorely needed to sustain chronically disturbed individuals within community-based settings.

The issues of effective treatment must be raised in the context of services currently being provided to our entire client population and to recipients of "ancillary" mental health services. We must first question the appropriateness of mental health training today in light of the archaic, entrenched system of care which has been unable to deal effectively with the needs of a growing diverse client population.

In a recent survey of our mental health outpatient operations in Los Angeles County (Los Angeles County MIS 1985), it was noted that approximately 60 percent of outpatient resources continue to be allocated to the individual outpatient treatment modality. Less than 25 percent of outpatient resources are allocated to group treatment services, and less than 5 percent to case management functions. In addition, target populations at risk, such as ethnic minorities, the aged, and children and adolescents, continue to be significantly underserved relative to their representation within the general population.

The structural configuration of our service delivery system remains virtually unchanged despite the significant difference and shifts over the past 10 years in the client population being served.

The need for board-and-care residences to provide support services such as socialization and rehabilitative day treatment programs has been well documented (Jones 1975). A recent survey during the Medi-Cal Consolidation Feasibility Study in Los Angeles County (Honnard and Waxer 1983) indicated that the vast majority of individuals placed in board-and-care homes following institutionalization received medication as a primary form of treatment, with few additional social support services or other kinds of therapeutic intervention. While the needs of the aging have been well documented in Los Angeles County, the county continues to commit less than 4 percent of our total resources to this target group. While certain target populations need mobility of service, our services continue to be delivered from facilities housing multidisciplinary staff where most of the space is still allocated to the individual treatment office. The facility may be geographically accessible, but the configuration of office space still determines the predominant mode of treatment.

Mobile response capability, community support services, case management, socialization programs, and services to board-and-care homes have all been identified (Jones 1975, Honnard and Waxer 1983), as of the highest priority in dealing with the issues of recidivism and decreasing utilization of State hospital days. Self-help organizations and programs such as Project Return in the Los Angeles area (Levine and Spaniol 1985, Zinman 1982), have been invaluable resources to service providers in the development of support services to a chronically disabled population.

Thus, while recognizing that our system of care has been grossly underfunded, we have nonetheless failed to fund our stated priorities adequately through reallocation of existing resources and through redesign of some features of our service delivery system.

It is imperative that ethnic minority training programs adequately prepare the student to understand the current service delivery system, stated priorities, and the skills needed to work with an increasingly disturbed patient population. The public and media attention currently given to the plight of the homeless mentally ill will require that public resources for the mental health delivery system be increasingly allocated to the kinds of services described above, as well as to crisis intervention and emergency mobile response capability. While mental health professionals may expect to use their skills in the "coordination of services" and other entry-level administrative tasks and responsibilities, the reality will be a greater demand for participation in direct service activities.

ETHNIC MINORITY MENTAL HEALTH MANPOWER--LINGUISTIC AND SPECIFIC CAPABILITY

Specifically, what staff resources would improve the service delivery system for ethnic minority clients?

1. Trained mental health staff with linguistic capability, particularly to serve newly arrived refugee populations.

2. Trained mental health staff to provide culturally specific services.

While the need for linguistic capabilities is quite apparent in view of the growing number of monolingual populations, the issue of culturally specific services, by in large, remains rather vague and undefined.

Ethnic minority service development cannot be divorced from the socioeconomic structure of particular communities. The issue of ethnic minority training needs must be discussed in the context of the demographic characteristics of the community served by the community mental health system.

The prevalence of a particular ethnic minority population does not, by itself, dictate the kinds of service issues the community mental health system must address. Rather, community dynamics, sociopolitical structure, and demographics of the particular ethnic minority community determine the issues. Even for ethnic minority communities sharing a common language, such as Hispanics, social cultural orientations and value systems vary greatly. These differences are particularly evident as the increasing numbers of refugee populations have recently immigrated to this country. Degree of acculturation is certainly a significant factor in the heterogeneity of ethnic minority populations.

"Culturally specific" may indeed refer to the ability of a staff to identify the common elements of the cultural stresses being experienced by client populations and to institute the appropriate treatment methodology and modes of intervention.

At a recent workshop sponsored by the California Conference of Local Mental Health Directors (Hatakeyama 1986), two service agencies presented their programs on dealing with Asian/Pacific refugee populations and Hispanic/Latino refugee populations. While the two groups differed greatly in their cultural adaptations to the stresses of refugee status, they showed some common elements. Both groups had similar experiences of separation from family, political harassment, and difficulties in employment. From the discussion, it was evident that the dynamics of "refugee status" became the dominant issue for therapeutic intervention. Both programs were "culturally specific" relative to refugee status. While the therapist's understanding of the sociocultural nuances and different behavioral patterns of adaptation was important with both groups, the overriding issue of the stresses of refugee status was clearly the focus of the therapeutic process. Indeed, the groups had more in common with each other than with their respective cultural counterparts within the community who had experienced a high degree of acculturation.

The diversity of recently arrived Hispanic populations, thrust together in an urban ghetto, struggling for survival, sharing a common language but of different nationalities, has created a new dimension for the ethnic minority professional who may be native to this country. Such a community is vastly different from the well-contained Southwestern ethnic community that shares historical roots and values.

I suggest that "cultural specificity" in treatment not be confined to linguistic/geographic/ethnic similarities, but also include the similarities in experiential factors that affect the emotional and psychological well-being of the target population.

The struggle for ethnic identity that characterizes ethnic minority populations native to this country and subjected to racism and prejudice may not be as acute an issue for newly arrived refugee populations who bring with them a strong sense of national identity. However, they share often-overwhelming problems in social adaptation and, at times, the trauma of political persecution. Recognition of these differences may lead to very different strategies of intervention within specific target communities.

ETHNIC MINORITY MANPOWER AS AN AFFIRMATIVE ACTION ISSUE--SHOULD THE SERVICE CHANGE?

It is interesting that after nearly 15 years of Federal funding of comprehensive community mental health services in areas with high percentages of ethnic minority populations, our system faces a critical shortage of trained ethnic minority professionals. The Community Mental Health Centers Act of 1963 and 1965 sought not only to provide comprehensive community-based services within economically disadvantaged communities, but also to recruit, train, and develop staff indigenous to the catchment area of the particular service provider. The development of a cadre of paraprofessional staff within the community mental health programs was intended to help develop services attuned to specific local needs. It is obvious that, after years of Federal funding, community mental health programs for the most part have failed to develop career ladder opportunities leading to an increase in the number of ethnic minority professionals on their staffs. While agency administrators have quickly pointed out the impact of reductions in funding, licensure, and other program reimbursement requirements/restrictions on ethnic minority staffing levels, the fact remains that the minority staff members have been the most vulnerable to those changes.

Throughout the State of California, ethnic minority staffing patterns are disproportionate to the numbers of ethnic minority members within the general population.

A recent manpower study of ethnic minorities within the staff of the Los Angeles County Department of Mental Health (Martinez 1983), indicated a glaring underrepresentation at all staff levels, particularly in middle management and administrative positions. This underrepresentation was further compounded by the fact that ethnic minorities are often hired to provide services to a minority community and are glaringly absent from any staff that does not serve a predominantly ethnic minority population.

Thus, the issue of ethnic minority recruitment and representation on staffs is rarely limited to the question of affirmative action and equity as an end in itself. Rather, it is tied to the issue of service delivery to the ethnic minority population represented by the particular staff member. The constructs of a particular recruiting effort then impose a set of expectations and structure of practice quite different from those of the nonethnic minority staff. Ethnic minority professionals are, therefore, placed in practice situations experientially different from those of their colleagues.

It is particularly important to emphasize the recruitment and training of ethnic minority mental health professionals to provide services to a broad spectrum of the client population. The recruitment, training, and development of ethnic minority staff must not be limited to providing services to the ethnic minority community, but rather, must aim at developing skilled clinicians who can provide effective services to the entire client community.

It is an institutional responsibility to be responsive to the most significant segments of the populations in the area being served. It should be an inherent expectation at all staff levels that desired skills and qualification levels include the ability to provide services to a diversified and changing client population. This should be particularly true in clinics and institutions where ethnic minority staff are underrepresented.

DISTINGUISHING BETWEEN SERVICE DELIVERY STRATEGIES AND TREATMENT MODALITIES/METHODOLOGIES

Are these indeed "different" for target populations? Let us reexamine whether or not there is anything unique in effective treatment methodology for ethnic minorities beyond the need for sensitivity to culturally specific behavioral indicators.

We must distinguish between service delivery strategies and treatment modalities/methodologies as we describe the differences in the delivery of services to ethnic minority populations. The County of Los Angeles serves as a microcosm that has significant implications for curriculum development and research.

The social and economic deprivation of barrio and ghetto communities, as evidenced by substandard housing, poor education, and high unemployment, has created a situation in which mental health resources and services are often the primary resource in dealing with a multitude of needs. Services range from early intervention and community outreach efforts to crisis intervention and direct services for acutely distressed individuals whose behavior may pose a threat to themselves or their neighbors.

As a consequence of a lack of meaningful treatment alternatives, many jails are filled with a disproportionately high number of ethnic minorities who have entered the system through "mercy bookings" or as a result of misdemeanor/borderline antisocial behavior. The growing number of individuals arriving at our psychiatric emergency rooms with a subsequent dual diagnosis of mental illness and substance abuse, as well as the growing number of chronically mentally ill, is a testimony to the challenge facing our schools of professional training. Not only must they train the ethnic minority professionals so needed within our service delivery system, but they must also develop the training resources needed as the system shifts its focus to treating a more severely and chronically disabled population. Treatment intervention has required the presence of other human resources, which affect our ability to stabilize and sustain the individual within the least restrictive environment possible.

Treatment principles and approaches to crisis management and stabilization, the brief therapy model, diagnostic assessment, treatment planning, case management, and support services may be the framework for the development of effective services to a growing population of severely and chronically disabled individuals, both members and nonmembers of ethnic minority groups, who face a multitude of needs.

As we review the clinical programs of agencies serving a population in which ethnic minorities predominate, we note that there is nothing "different" in the treatment methodologies they offer. Individual therapy, group treatment services, medication, and day treatment programs continue to constitute the framework of services, just as they do for non-ethnic populations. Thus, given the framework for service and the fact that there is not a substantial difference in the therapeutic process and treatment modalities adopted, the ethnic minority mental health professional must be trained to work effectively with both minority and nonminority mental health clients.

What may indeed be different are the strategies and techniques of intervention adopted by a particular agency to ensure accessibility of services. The co-location of facilities within ethnic minority communities has resulted in higher utilization of services. Another factor has been the deployment of staff who have linguistic capability to serve monolingual target populations. The strategies for intervention must include coordination and linkages with other human service providers and agencies within the target community.

Of major importance is willingness of agencies and institutions to develop clear, well-defined policies regarding facility location and staff deployment. Strategies of intervention and techniques for engaging ethnic minorities in the treatment process may indeed be unique, as in the research project developed at the University of Southern California (Acosta et al. 1983, Evans et al. 1984) which used visual aids to prepare ethnic minority clients for a treatment process.

Often ethnic professionals are asked to help an agency ensure accessibility of services in ways that can only be addressed by the organization's commitment to adopting the necessary policies and reallocation of resources.

The overriding issues of distributing resources equitably and increasing the visibility of ethnic minority professionals within particular institutions should not rest on the issue of proving that treatment strategies or modalities are "different" for ethnic minorities.

TRAINING IMPLICATIONS

The training of ethnic minority health professionals must be viewed within the context of the shift in focus of public resources to the treatment of more severely and chronically disabled populations. This focus requires skills in crisis intervention and stabilization services, diagnostic assessment, and evaluation.

The ability to communicate is essential in developing resources, networking, and enhancing the capability of other service providers in crisis intervention and other services. Communication is essential to engender community and political understanding of the mental health system's philosophy, goals, and objectives. Ethnic minority mental health professionals should be trained in skills that will place them in leadership positions, where they can influence policy decisions.

The mental health profession has recognized the need to strengthen the relationship between academic institutions and fields of practice. However, we have not yet truly defined the nature of that relationship. Beyond offering field experiences, we have not defined specific ways service providers and academic institutions can participate jointly in the development of a curriculum that would more effectively train mental health professionals to meet the changing needs of our clients. As service providers, we have been negligent in failing to invite academic institutions to participate in applied research to help us more clearly define and measure effective treatment. Where such research has been undertaken, policy implications for resource allocations and changes in the delivery system of care must also follow.

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CHAPTER 7

MENTAL HEALTH SERVICES DELIVERY TO MINORITY POPULATIONS: HISPANICS--A PERSPECTIVE

Nelba Chavez, Ph.D.

Effective delivery of mental health services to minority populations, particularly Hispanics, is a combined function of cultural attitudes, service parameters, delivery processes, and the particular "chemistry" that develops between the individual provider and the service recipient.

Should a disruption occur anywhere along this delivery line, the most highly researched and well-meaning of efforts are likely to fail. If the failure is not treated as a learning experience, the disruption tends to become increasingly problematic, with services intended for problem-solving delivery becoming misdirected between initiating agency and designated beneficiary.

Many mental health professionals have experienced the frustration at the manner in which a full volume of mental health services at one end of a pipeline can be so readily reduced to an ineffective "dribble" at the other. At least in part, this conference is a direct result of such frustrations.

The answer to the dilemma of service reduction is neither complex nor hidden and does not require overhaul of either services or system of delivery. It does require revised emphasis, heightened sensitivities, and a closer collaboration between professor and provider--those who teach and those who "do."

REVISED EMPHASIS

The story is told of a young Southwestern jeweler, a gregarious and successful man, who journeyed to the mountain regions of Brazil to purchase raw gemstones directly from native miners. Possessing genuine empathy for the hardworking entrepreneurs, though not understanding their language, he exhibited a universally cheerful and friendly demeanor, profusely thanking his host after each transaction and "signing" with the "OK" hand signal, the circled forefinger and thumb.

Gradually, his welcome in the community lessened, in spite of his sincerity and willingness to pay what were above-market rates in that country. Finally, his effectiveness all but gone, he prepared to board an outbound flight in Rio de Janeiro. It was only in bemoaning his apparent failure to communicate that he learned from a more experienced countryman that in Brazil the American "OK" signal stood for an unnatural physical act. Our friend had spent several weeks in the mountains and jungles of a strange land, thanking his hosts with obscene gestures!

The point illustrated is that intentions, regardless of how honorable or well motivated, are not enough to ensure effective cross-cultural communication. What appears perfectly acceptable in one culture may be totally offensive in another.

In spite of his social/cultural errors, our friend was successful in his commercial endeavor. He was looking for something out of each relationship--gems--and was able to secure them before committing his faux pas.

As mental health professionals, however, it is the relationship itself that we strive for, so that we may maintain a continuing and increasingly productive communication. With respect to the Hispanic mental health client, however, many of us have been unwittingly guilty of saying "OK" with the wrong signal.

That signal has been an undeniably "official" one; we have gone, and continue to go, "by the book." The book, however, is missing a chapter--a highly significant one that deals with cultural uniqueness and the role that this uniqueness plays in interpersonal communication.

"Cultural uniqueness" is not academic nomenclature. It is a phrase used to describe a quite literal physical, emotional, and behavioral distinction of a people. While European immigrants traditionally hastened the absorption process, Hispanics did not; and to this day Hispanics strive to retain a cultural identity within the dominant population. They are a family-oriented and rapidly growing minority. Author of Megatrends, John Naisbitt (1982), states that "none of the new groups individually can begin to match the numbers and the potential influence of Spanish-speaking Americans." Their population is increasing at a rate six times faster than the nation as a whole. Over two-thirds identify Spanish as their mother tongue, and more than half speak it in their homes. Concepts such as machismo (manliness), confianza (confidence), respeto (respect), verguenza (shame), and orgullo (pride) predominate in the culture. There is a strong tendency toward self-reliance and the resolution of problems within the family or church. Traditional gender roles are a part of the culture. Comparison of cultural values, while showing Europeans in a conquering relationship with nature, described Hispanics as exhibiting instincts for harmony and community interdependence, for tranquility, and sacrifice for others. The Spanish language, el concepto de familia, and value system separate them from other cultural groups. Yet they are engaged in a period of transition, attempting to adapt to the dominant value system while retaining their own. Treatment providers need to be aware of these values and emphasize their validity.

Historically, this group has underutilized available mental health services. Ramos and Torres (1984) show that the rate of Hispanic admissions to state and county mental hospitals is less than half that of black Americans. The Los Angeles County Department of Mental Health (1981-1982) shows that the rate of Hispanic admissions to mental health facilities is one-half of their population percentage, while Anglo admissions constitute a rate equal to 80 percent of the population percentage (Hough et al. 1983).

These low utilization rates occur in spite of recurring cultural pressures, including poverty, poor housing, low educational attainment, unemployment, the necessity for adoption of bicultural values, and identity conflicts.

In this context of inordinate life stresses, Mexican Americans ". . . should be over-utilizing mental health services" (Latino Task Force on Community Mental Health Training 1974), for they are over-represented in institutions confining those guilty of anti-social behavior.

Unfortunately, underutilization of services is frequently misdiagnosed as either lack of need or inability to "verbalize," to "be introspective," or to "gain insight." Too frequently, institutional nonresponsiveness to populations served is overlooked as a contributing factor to underutilization. It is often assumed that Mexican-Americans are not "psychologically minded," and that they do not have the "equipment" to engage in psychotherapy--an assumption that may lead to the development of a self-fulfilling prophecy in the initial interaction between client and therapist.

Many current institutional practices deny the Hispanic client entrance into the mental health system. Because of the red tape, the ambiente and the lack of personalismo, many of the current institutional practices deny the Hispanic client entrance into a mental health system. In one study concerning mental health services and Hispanics, it was found that part of the reluctance by Hispanics to seek help was related to "pride and humility" (Karno and Edgerton 1969). Hispanics seeking services felt they were looked down upon because of their unfamiliarity with procedures required to receive help. The implication was that everyone was expected to be familiar with procedures, to express feelings readily, and to verbalize them in treatment.

Also, many Hispanics continue to attach verguenza (shame) to receiving treatment for mental illness. They are too proud and sensitive to expose their personal problems to outsiders. For many, there continues to be a reliance on the traditional family for solving their own problems. They believe in protecting and caring for troubled family members. Sending them to a clinic or hospital for treatment may be interpreted as a form of rejection.

To date, the emphasis on mental health services for minorities has been on forms of treatment. It needs to be shifted to palatability of treatment for individual populations. Such palatability is a direct function of mutual language, mutual culture, and cross-cultural sensitivity.

HEIGHTENED SENSITIVITY

There is a relationship between the availability of bicultural/bilingual staff and retention rates. For non-Hispanic staff, the challenge becomes more specific. The program guidelines for the community mental health centers (CMHC) services to minorities act, issued by the National Institute of Mental Health in 1979, state that

> Staff should become aware of and be sensitive to the unique life experiences and cultures of many minority clients which are related to lifestyles developed from the clients' experiences with racism. The minority client's psychological attitude toward the CMHC and its staff may include distrust and inhibitions to being genuinely self-disclosing. Board and staff members should be aware that this is likely to have a profound impact upon the development of rapport and to adversely affect therapeutic relationships with minority clients. Appropriate responses to this situation will require sustained attention to the manner in which services are planned and provided (p. 18-2).

The "adversely affected therapeutic relationships" generated by lack of cultural sensitivity often reveal themselves in the form of misguided diagnoses; for example, the 28-year-old Hispanic woman who, in supporting her parents and extended family, was diagnosed as having a "mother" complex and attempting to emulate her father's role and become a husband to her mother or the adult men and women who, in accordance with their culture, remain in the family home until married, yet are diagnosed by Anglo therapists as "sheltered" or "passive-dependent."

The diagnosis, of course, is the cornerstone on which treatment methods are built. Tragedy can result from error.

A key factor in successfully delivering mental health services to Hispanic populations is the understanding that their members are opposed to the manner and not the concept, of such services. Levine and Padilla (1980) report several studies showing that conceptual negativism has not been the case. A study by Acosta and Sheehan (1976) of Anglo and Mexican-American college students showed that the Hispanic group possessed a considerably more favorable attitude than the Anglo group toward the potential usefulness of therapy.

In a study at La Frontera Clinic in Tucson, Arizona (Chavez 1979), the findings suggested that the majority of Hispanics came to the clinic equipped with the insight and readiness to utilize the mental health services that they had requested. In addition, many of the respondents were eager to articulate their problems to someone who was sensitive, competent, and willing to facilitate the problem-solving process. Hence the individuals in this group, although economically poor and of relatively modest educational backgrounds, did not fit the stereotype of the lower socioeconomic person who expects magical solutions to solve his or her mental problems.

CLOSER COLLABORATION BETWEEN PROFESSOR AND PROVIDER

How, then, to provide sufficient numbers of therapists who are sensitive, competent, and willing to facilitate the problem-solving process.

The first step is to recognize that the bilingual/bicultural gap between service providers and service consumers will never be bridged, and to proceed accordingly. The second step is to sensitize new, non-Hispanic providers to methods of service delivery and to environmental conditions that generated the search for help in the first place. The third step is to revise the manner in which services are delivered, and to reach back into the training process and sensitize those not responsible for instilling in counseling students the entire therapeutic knowledge base. The fourth step is to hold seminars at mental health centers for educational, clinical, and interested community participants. Mental health staff members that are sensitive to and knowledgeable about providing effective cross-cultural services to minorities should serve as educational resources.

The sensitizing process, which is already sufficiently challenging, has been supplied with additional roadblocks in recent years.

With the advent of the community mental health "revolution" of the 1960s and Federal legislation mandating specific services, particularly to those who were unserved or underserved, a greater proportion of Hispanic populations in the United States began to receive mental health services. Alternatives to "traditional" care became available to those who because of cost, inaccessability, and/or psychological barriers had not begun to receive mental health care.

Unfortunately, this psychiatric endeavor failed, largely at the expense of women, children, and minority populations.

Many of the CMHCs that were established in communities with significant Hispanic populations suffered from a range of "effectiveness symptoms" all their own; these CMHCs were dominated by a psychotherapeutic orientation learned primarily by middle-class Anglo therapists in primarily Anglo institutions. Although dedicated and well-meaning, these new practitioners brought to their centers what they knew, but since "cultural relevance" was not on their class schedules, they did not bring this as part of their knowledge.

Subsequently, the literature began to reflect underutilization of mental health services by Hispanics. The Federal Government responded by beginning to pay specific attention to the special populations that defined catchment areas. In the late 1970s it became a requirement that CMHCs develop tailor-made programs that took into account language, cultural differences, and the needs of special populations. Through the establishment of the President's Commission on Mental Health (1978), and the continued interest of various task forces established by the commission, many of these neglected populations came to the forefront. The concept of "cultural relevance" had been effectively planted.

Unfortunately, the concept failed to take hold. The policies recommended by the presidential commission passed with fanfare but were never implemented. "Cost efficiency" became the byword of federally funded mental health delivery systems. Decentralization through block grants became the norm. The issue of the 1980s was funding. There was an unspoken but real philosophical shift from mental health centers to mental illness centers. Strict admission criteria became the rule, as did tightening funding formulas, unit reimbursement, and provision of services first to those most identifiably in need, i.e., the chronically mentally ill.

The concepts of intervention and of prevention became officially outdated. A "collision of mission" occurred with centers founded on principles established in the 1960s staffed with people educated in the 1970s to deal with the mental health realities of the 1980s.

Outreach, visibility, elimination of red tape, platicas, and other elements of cultural sensitivity became, in the bureaucratic view, low-priority items that were replaced by increased red tape, hard numerical objectives, and indications of dire consequence to facilities failing to meet them.

The most dire of those consequences was left unspoken--the practical elimination from official thinking of the very idea of cultural sensitivity. The emphasis, which shifted from humanistic to economic, remains so today. The effectiveness of treatment programs is measured and reimbursed not in terms of family renewal or redirected lives but in units of service.

Humanists prevailed in the 1960s and 1970s. In the 1980s, the community mental health delivery system is under the control of "statisticians."

To demonstrate economic effectiveness community mental health centers must acknowledge, meet, even exceed their numerical quotas. To demonstrate professional effectiveness, however, the mental health profession must go beyond rigid dicta and strive to spread existing human and material resources even more efficiently among an ever-increasing client base. To do so, to balance reduced time with heightened impact, it falls upon us as teachers and practitioners to reinstitute cultural sensitivity as a first priority and to make it a therapeutic mainstay in our dealings with minority populations.

The first step is to define "cultural sensitivity," which is not a euphemism for "speaking Spanish." Language alone is insufficient to overcome communication hurdles. The development of true cultural sensitivity involves a process of acculturation of "tuning in" or "becoming." It is unique because it cannot be pretended or faked. It is either present or it is not. If it is, no mechanical manifestations are required; the "right" actions will be virtually automatic. Cultural sensitivity is a product of interest, attitude, effort, and time.

In most instances interest is a product of incentive, curiosity and, ultimately, understanding. The primary incentive for true professionals in the mental health field should be increased awareness of the factors that contribute to behavior. In turn, such awareness leads to a greater ability to empathize with the problems an individual brings to therapy. As awareness grows, so does the natural tendency to determine what lies beyond. Ultimately, fascinating, professionally related discoveries lead from one to another, until true understanding dawns. It is a process that we are taught to use to guide others and one that we should apply to ourselves as therapists.

Once interest has genuinely developed, a therapist's manner of dealing with its object traditionally alters. This behavioral shift stems from an attitudinal one. A willingness to further the process follows, as does, where possible, a commitment of the time necessary to do so.

The acquisition of true cultural sensitivity, then, is not an academic process; it is and must remain an experiential one. One cannot "walk a mile in another person's moccasins" while seated at a desk.

The key to optimal effectiveness in treating Hispanic clients is environmental empathy. The key to environmental empathy, or cultural sensitivity, lies not in its observation but in its absorption. One absorbs culture from direct and indirect experiences contacts. Cultural absorption occurs by allowing oneself to be touched by another way of being.

Given the constraints of traditional practice, to which must be added ever-growing "efficiency" expectations, it is not suggested that aspiring and practicing therapists and their teachers exchange their daily schedules for the on-site contemplation of life in the barrio. It is suggested that concerned professionals be granted access to the technological innovations available in other classrooms, as well as bringing the barrio into the classroom through the medium of video and other learning experiences.

In the Hispanic communities surrounding La Frontera Center, outreach proved so successful that it had to be halted since we could not respond to the excessive demand for services. The magnitude of interest exhibited is sufficient, in our view, to ensure the accessibility of individuals, institutions, and lifestyles to the "prying eye" of a sensitive and directed videotape team bent on recording not the trauma but daily life as it occurs in the Hispanic community.

An amalgam of these observations and interviews, depicting the customs, the attitudes, the relationships, and motivations of a distinct and, to some, an otherwise unfamiliar culture would familiarize those currently engaged in being trained for therapeutic intervention with Hispanics. The observation and production of the video tapes would constitute a valuable learning experience. The team would consist of both professors and practitioners, required by circumstance to focus on and share the experience, and bring its insights to their respective constituencies. Those insights would be broad in scope.

The team and the tapes' viewers would learn that residents of the barrio see their neighborhood as a retreat or a comfortable, warm, and familiar homeland, which often contains the parish church, grocery, school, and park. The neighborhood serves frequently as a self-contained living center for much of the resident's life. Because the mental health services' client is removed from this support system, particularly in times of personal trauma or stress, treatment barriers are erected. Therefore, access is one of the key evidences of cultural sensitivity.

The video team would learn about the role of language in treatment. With half of the Hispanic population speaking their native tongue at home and a substantial percentage speaking only Spanish, the observer would immediately recognize the futility of attempting to diagnose and treat someone with whom even the exchange of names is a problem. The use of nonprofessional interpreters to relay a Hispanic client's most intimate and self-baring concerns, would directly conflict with his or her inherent feelings of pride, self-reliance, and shame.

Through the use of videotape, the therapist, the professor, and the therapist-in-training would see that the Hispanic male who reports solely physical manifestations may be using this discussion of somatic problems to introduce emotional problems forbidden to him by machismo.

The simplicity and directness of the life portrayed on videotape would compare starkly with the complexity and occasional officiousness of simply gaining access to a CMHC, which demonstrates that "red tape" can be more than inconvenience to a Hispanic mental health client; "red tape" can be an insurmountable barrier to service.

Video is more than a foreground medium; it has a depth of field that brings into view the unemployed, the young, the very old, and the living conditions that contribute to the situational stresses that can inhibit treatment progress. Awareness of the kind of situational stresses that impact minority clients permits skilled therapists to draw out their existence, thereby eliminating one more barrier to effective and efficient treatment.

By introducing the world of the barrio to the therapist or teacher interested in developing true cultural sensitivity, video also exposes the astute observer to the spoken and unspoken needs that should predominate in the development of treatment programs. Ultimately, it will be the effective response to the mental health needs, as opposed to bureaucratic formulae, that will most directly impact on improved mental health services.

In the area of mental health, the Hispanic community does not need to recycle its barrios. It needs to recycle people through its barrios. A communications bond, not just a communications capability, must be developed between those who require services and those who provide these services. Non-Hispanic therapists must become more familiar with their own culture to assess how it varies from the lifestyles of those citizens whom shall be treated. Observational skills must be developed so that nuances of language, expression, and body language can be effectively interpreted. Life experiences, not just textual revelations, must be incorporated into training and treatment programs.

In the schools, "Reality I" should become the core course, and instructors should be the first to take this course. Reality has to do not only with the acquisition of knowledge, but its application. Application includes technical knowledge, assessment, appropriateness and timing, dynamics, design, administration, revenue, and cost. Those who teach should be required by professional edict to immerse themselves in the community, so that they can constantly monitor how their teachings are being interpreted and delivered and whether their impact is optimum. If their impact is minimal, then trainers should examine the reason for this ineffectiveness.

Attention needs to be focused once more on the question of overall emphasis: Do we treat the individuals who are suffering the effects of the system or do we treat the system? If it is the latter, the entire scope of professional training requires change and ongoing scrutiny.

Providers of professional training and practitioners of the theories thus taught need to totally rethink the existing "us-and-them" philosophy and collaborate on research, interpretation, and application so that the gap between teacher and student becomes virtually indistinguishable. Feedback feeds thought; there has been very little professional nourishment in recent years.

Cultural competence in mental health practice can be assessed in the same manner that competence is judged in any other field. Outcome is the ultimate test. Interim tests include familiarity, facility, the ability to repeat successful actions, and productivity. Productivity in mental health practice must be judged subjectively, as well as quantitatively. In the end, resolution of accurately diagnosed emotional trauma is the objective of our profession and should serve as well, by whatever parameter, as its scorecard.

The major gaps that exist in the field of mental health are in the area of human resources. There are not enough bicultural/bilingual practitioners and paraprofessionals or cross-culturally trained non-Hispanic therapists. As our population increases, so do the numbers of individuals exposed to the stresses of bicultural living. Aggressive recruitment of minority mental health personnel must once again take place. Those of non-Hispanic descent who show an aptitude for mental health work and an interest in minority populations must be diligently nurtured, so that the seeds of cultural sensitivity might be planted.

CONCLUSION

If we are to determine the minority mental health direction of the 1980s and 1990s, we must do more than reflect upon past efforts; we must rethink and we must act. We must understand that our profession not only treats the people of this nation, it is funded by them. We must place ourselves higher in the sphere of competitive funding through intense and directed communication and deal with our clients, in the interim, as if that communication had already proved successful.

Finally, the dilemma of inadequate services can be influenced by revised emphasis, heightened sensitivity, and closer collaboration between professor and provider. Cultural sensitivity is the access bridge from the barrio to the community mental health center.

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CHAPTER 8

THERAPISTS' CREDIBILITY AND GIVING: IMPLICATIONS FOR PRACTICE AND TRAINING IN ASIAN-AMERICAN COMMUNITIES*

Stanley Sue and Nolan Zane

Nearly a decade ago, a group of Asian-American psychologists organized a training conference sponsored by the National Institute of Mental Health (NIMH) to discuss, among other issues, how to effectively deliver mental health services to Asian-Americans and how to train students to work with this population. The fact that we are addressing some of the same issues at the present workshop indicates that the concerns over service delivery and treatment still remain. Nevertheless, we have some advantages. There has been a decade of additional research and mental health programs with Asian-Americans. The level of expertise has increased, and with the growing populations of Asian-Americans and other ethnic groups, cross-cultural issues in the mental health field are becoming more of a priority.

We have been asked to review our research and to present a reinterpretation of meta-analysis of some of the work. Several points are made. First, much of the research findings on Asian-Americans need to be transformed from an informative or content level to an operational or process level. Without this transformation, the findings can serve to uncover problems and to sharpen the need for change but fail to concretely suggest the direction of change. Second, two key ingredients in psychotherapeutic effectiveness are therapist credibility and giving. Therapists must have an ascribed and/or achieved credibility when working with Asian-American clients. These clients must also receive something (i.e., a "gift") from treatment. Third, by defining credibility and giving as important processes in working with Asian-American clients, recommendations for education and training can be specified. It should be noted that our ideas or speculations are based on not only research work but also our collective experiences as a therapist, researcher, and previous director of training of an Asian-American clinical psychology internship program. Let us begin by reviewing some of our research findings and indicating the necessity to transform the findings into an operational level.

*Note: An earlier version of this paper appeared in the American Psychologist.

INSIGHTS FROM RESEARCH

Our initial research efforts were focused on Asian-Americans who used mental health services. Among college students who received treatment from a campus psychiatric clinic, Asian-Americans were severely underrepresented, more clinically disturbed, and more likely to attend fewer therapy sessions than non-Asian students (Sue and Sue 1971, Sue and Sue 1974). Obviously, the nature of the sample (i.e., college students) limited the kind of generalizations that could be made. We then sought to examine Asian and other ethnic group clients at community mental health centers in the Seattle area (Sue 1977). We obtained data from over 13,000 clients seen in 17 community mental health centers over a 3-year period. Asian-American clients were again found to be underrepresented by a factor of 3.5 (from their expected number in the local area), to exhibit a higher proportion of severe disturbances, and to terminate treatment very quickly. (Incidentally, blacks and American Indians were overrepresented and Hispanics underrepresented in these centers; all ethnic groups had a higher premature termination rate--dropping out of treatment after one session--than whites.)

In view of the fact our studies on Asian-Americans were based upon different populations and different measures of clinical disturbance, we were increasingly confident of the generality of the findings. The next tasks were to explain the findings and to offer suggestions that might have therapeutic or policy implications. In explaining the data, we felt that many Asian-Americans perceived psychotherapy to be useless, foreign, or stigmatizing. Therefore, only those individuals who were the most severely disturbed and who had exhausted all other forms of help would tend to utilize services in the mental health system. The high rate of premature termination of Asian American clients from treatment is attributed to the clash of Asian cultural values and those of Western (or mainstream American) values as well as to the inability of therapists to adequately relate to Asian-American clients.

Many Asian-Americans, particularly those who are less acculturated to this society, are unfamiliar with, or have little faith in, Western forms of psychotherapy. Furthermore, Asians and whites differ in their conceptions of mental health and disturbance (Lum 1983, Sue et al. 1976). Compared with whites, Asians were found to believe that mental health was due to the avoidance of morbid thinking and that mental disturbance was caused by organic factors. If the practice of psychotherapy requires clients to focus on painful or negative (i.e., "morbid") thoughts and de-emphasizes somatic interventions, many Asian-American clients may find the process of psychotherapy to be inconsistent with their beliefs. Note that we are not at this time making implications concerning the veridicality of client beliefs or the appropriateness of therapeutic practices. At this point, attention is being drawn to the possible discrepancy between client beliefs and therapy practice. It also seems reasonable to assume that therapists often have difficulty in relating to Asian-American clients. Many of these clients have limited English proficiency, and few mental health facilities have bilingual and/or Asian-American therapists. The problem is further complicated by the fact that most mental health training programs fail to train professionals to work with members of ethnic minority groups (Bernal and Padilla 1983, Chunn et al. 1983).

IS THE RESEARCH HELPFUL?

Because of the underutilization of services, the high dropout rates, and the unresponsiveness of services to meet the needs of Asian-Americans, ethnic researchers and practitioners advocated changes in the mental health delivery system. The changes had to do with the process of match or fit: Treatment should match or fit the cultural lifestyle or experiences of clients. Otherwise, Asian-American clients would continue to find treatment foreign, strange, or culturally inconsistent. Match or fit implies that (1) more Asian-Americans who presumably are bilingual and/or familiar with Asian cultural values should be recruited into the mental health field, (2) students and therapists should acquire knowledge of Asian-American cultures and communities, and (3) traditional forms of treatment should be modified since they were geared primarily for mainstream Americans.

These tasks have been difficult and problematic to achieve. For example, in trying to recruit Asians who are fluent in an Asian language, graduate programs are often reluctant to admit Asians if their English verbal skills are low. Another problem is that few training programs are willing to offer Asian or ethnic-oriented courses. On the other hand, if programs expose students to lectures and readings on Asian-Americans, there is also a danger over the application of this knowledge. We find that many individuals who study cultural differences begin to apply their acquired knowledge in inappropriate ways. Years ago, when one of the authors was a clinical intern, a case conference was held in which a Chinese-American client was being discussed. The person presenting the case contrasted Chinese and American cultures and proceeded to apply the contrast to the client in a literal and stereotypic fashion, despite the fact that the client was a fourth-generation American. The point is that in working with Asians, no knowledge of their culture is detrimental; however, even with knowledge, its application and relevance cannot be always assumed, because of individual differences among Asian-American clients.

Other issues are raised by the "match-or-fit" concept. Isn't it impossible to gain sufficient knowledge of all Asian groups or even of different ethnic minority groups? If traditional forms of treatment should be modified, does this mean that popular forms of Western treatments such as psychoanalysis, Gestalt therapy, humanistic approaches, and behavior modification are inappropriate? In what ways should therapy be modified? Is match important to clients? The point is that the notion of match brings forth a whole host of problems.

Ethnic mental health research has been successful in documenting deficiencies in service delivery and in justifying the need for changes. It has been less than effective in suggesting meaningful techniques or processes that should be used in therapy and the kinds of specific training experiences that students should have. Thus programs attempting to address ethnic issues have frequently been unable to accomplish more than the offering of a new course on ethnic mental health, the incorporation of ethnic content into existing courses, providing clinical field experiences in settings with multiethnic clients, or having an occasional guest speaker or workshop on ethnicity. Such programs generally emphasize the importance of knowledge of ethnic groups, being flexible in therapeutic practice, interpreting assessment measures with caution, and self-examination for ethnic bias.

While such tactics represent a first step in developing an ethnically responsive program, we have reached the point where it is necessary to review current practices and suggest recommendations for the future. We would like to reinterpret some of the research findings in an attempt to distill two basic processes (i.e., credibility and giving) that are important to consider in working with Asian-American clients. These two processes are not the only ones that are important in treatment; nor are they important only for Asian-Americans. Rather, credibility and giving are *particularly* relevant considerations in working with Asian-Americans. Credibility refers to the client's perception of the therapist as an effective and believable helper. Giving is the client's perception that something was received from the therapeutic encounter. The client has received a "gift" of some sort from the therapist. Credibility and giving are not new concepts in treatment. They are related to the much-discussed notions of expectancy, confidence, faith, and effectiveness in therapy. The purpose in discussing these two concepts is to show how they are especially relevant to Asian-Americans and how they can be goals for training programs. To understand their importance, let us examine previous suggestions for how to conduct therapy with Asian-Americans.

As mentioned previously, most investigators (Sue and Morishima 1982) have attributed the reluctance of Asian-Americans to use mental health services and to drop out of treatment to the fact that treatment procedures are geared for Western cultures. Consequently, many have suggested that therapists conduct culturally responsive forms of intervention. For example, Asian-Americans tend to prefer psychotherapists who provide structure, guidance, and direction rather than non-directedness in interactions (Atkinson et al. 1978). They are presumably more culturally familiar with structured relationships. Therapists are therefore advised to be directive. Ponce (1974) has recommended that mental health workers treating Pilipinos avoid approaches that emphasize communications, interpersonal feelings, feeling-touching maneuvers, or introspections. At least in the initial stages, an authoritative, as opposed to egalitarian therapist role, is more consistent with the helper-helpee relationship that Pilipino Americans expect. In a study of Chinese-American inpatients and outpatients at a mental health facility in Los Angeles' Chinatown, Brown et al. (1973) found that the patients were not responsive to insight-oriented therapy. Instead, the use of medication, attention to practical problems, and the application of immediate measures to handle perceived problems proved not beneficial to patients. The implications are that therapists should be structured, authoritarian, and work at a surface-problem level with clients.

While these suggestions for the role of the therapist may, indeed, be more culturally consistent with Asians, they raised difficulties. First, individuals who developed a theoretical style or orientation found problems in adopting a different style. Psychoanalytically or client-centered therapists would have to abandon to some extent insight or reflective techniques. Second, many Asian-American clients who were unacculturated seemed quite willing to talk about their emotions and to work well with little structure. Third, and most importantly, the suggestions were somewhat distal to the goal of effective therapy for Asian-Americans. If one examined the rationale for the suggestions, this became evident. For instance, imagine this dialogue:

Advocate: "Therapists need to be directive and structured in their interactions with Asian clients."

Skeptic: "Why?"

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Advocate: "Because the roles are more consistent with Asian cultures."

Skeptic: "Why is it important to be culturally consistent?"

Advocate: "There are probably many reasons. Clients do not find therapy so strange. They believe that therapists understand them and can appropriately relate to them. Therapy and therapists become more meaningful to clients. Also, with a knowledge of the cultural background of clients, therapists are in a better position to assess, understand, and facilitate change in clients."

Skeptic: "Then, being directive and culturally responsive are means to another end. That is, certain therapy strategies enhance the credibility of therapists and therapies to clients. This enhancement facilitates positive outcomes in treatment."

Advocate: "Yes."

This dialogue has been used to indicate that specific techniques deemed important for Asian-American clients may also be distal and far removed from the ultimate goal of effective therapy. Culturally consistent tactics, such as providing structure to clients, do not magically lead to effective therapy. Rather, the practices presumably result in a process such as increased therapist credibility and/or faith and expectancies on the part of the clients that then lead to effective treatment. Therefore, it may be wise to focus on the proximal process of therapist credibility than the more distal techniques. Instead of learning how to be authoritarian, directive, or structured with Asian-American clients, we should learn how to become credible with clients. While credibility may in some cases be aided by directness, it is not in other cases, and it may be influenced by many other factors.

Credibility

Many investigators have noted the critical role of therapist credibility in treatment. Frank (1959, p. 36) has stated: "Expectancy of benefit from treatment in itself may have enduring and profound effects on his physical and mental state. It seems plausible, furthermore that the successful effects of all forms of psychotherapy depend in part on their ability to foster such attitudes in the patient." Phares (1984) maintains that outcomes for clients are better when clients believe in their therapists and in the methods being employed.

How do Asian-American clients come to believe in therapists or therapeutic methods? At least two factors are important in enhancing credibility: ascribed and achieved status. Ascribed status is one's position or role that is assigned by others. For example, Shon (1980) has argued that communication patterns among various Asian-American groups are often governed by factors such as age, expertise, or sex. In traditional Asian cultures, the young is subordinate to the elder, the woman to the man, the naive to the authority, etc. (Bodde 1957). These role patterns, of course, are not true of all Asians; nor are they always desirable (such as the male-female roles). But these patterns generally exist in traditional Asian cultures. Credibility can also be achieved. Achieved credibility refers more directly to therapists' skills. Through the actions of therapists, clients come to have faith, trust, confidence, or hope. These actions may involve culturally consistent interventions and general therapeutic skills such as empathic understanding or ability to accurately assess clients.

The focus on the process of credibility also allows for an analysis of potential problems such as the following:

1. A nationally renowned psychotherapist is perceived by a client as being effective for Caucasians but not for Asians (perceived cultural difference in ascribed credibility).

2. A Young female therapist is perceived as having expertise but low status because of her age and sex (discrepancy over ascribed credibility characteristics).

3. An older, mature expert in psychotherapy fails to be effective with an Asian client (high ascribed credibility but low achieved credibility).

4. A client who is skeptical of therapy and of the therapist's training is pleasantly surprised that the therapist is quite skilled and helpful (low ascribed credibility but high achieved credibility).

Many other possibilities can be generated. The main point is that by analyzing credibility, we can begin to break the process of therapeutic effectiveness into components that can serve to direct our efforts in training. Ascribed and achieved credibility are related to one another. However, the lack of ascribed credibility may be the primary reason for underutilization of therapy, while the lack of achieved credibility may better explain premature termination. Many Asian-Americans believe that therapists in the mental health system cannot help them. They avoid services because of low ascribed credibility. Once in treatment, clients will drop out if therapists do not achieve credibility. In general, if therapists lack certain aspects of credibility with clients, other aspects must be strengthened. This will be illustrated later in a case example. Table 1 shows the potential effects of therapist credibility.

Table 8-1. Factors in credibility

	Achieved	
	Low	High
Ascribed		
Low	Client avoids treatment; if already in treatment, premature termination is likely.	Client avoids treatment; if already in treatment, expectations exceeded and may stay in treatment.
High	Client likely to enter treatment; high expectations are not realized so may prematurely terminate.	Client likely to enter treatment; high expectations are realized by the skills of the therapist.

Achieved credibility can be examined in three areas in which cultural issues are important. These are stated as hypotheses:

Conceptualization of the Problem. If the client's problems are conceptualized in a manner that is incongruent with the client's belief systems, the credibility of the therapist is diminished. Directly or indirectly, therapists often convey their understanding or conceptualization of the causal links in the problems or situations of clients. If these are antagonistic to clients, credibility may not be achieved.

Means for Problem Resolution. If the therapist requires from the client responses that are culturally incompatible or unacceptable, the achieved credibility of the therapist is diminished. For example, a therapist may encourage an Asian client to directly express anger to his father in family therapy. The response (expression of anger to father) may be quite ego dystonic because of cultural values.

Goals for Treatment. If the definitions of goals are discrepant between therapist and client, credibility of the therapist will be diminished. Sue (1981) cites the example of an Asian-American client who saw a counselor for vocational information. The counselor's goal in working with the client was to facilitate insight into deep underlying dynamics concerning motives and decisions. This was not the goal of the client who felt extremely uncomfortable in the session. In such situations, the therapist and client tend to judge the effects of treatment on different criteria. One may feel treatment is successful; the other, unsuccessful.

These three hypotheses are not intended to deny that therapists should simply strive to match clients. At times, the client's belief systems may be inappropriate; he or she may need to learn new and (previously considered) incompatible responses; and the client may hold inappropriate goals or the therapist may have to define other goals in order to address the client's primary goal. Nevertheless, therapists should realize that incongruities in conceptualization, problem resolution, or goals often reduce credibility. This diminished credibility needs to be restored or increased by demonstrating the validity of the therapist's perspective. Moreover, the incongruities should alert the therapist to reexamine treatment strategies. For example, are the treatment decisions guided by the therapist's limitations in understanding the culture and context of the client or by well-thought-out outcome considerations for this client? One important way to demonstrate validity and to enhance perceived and actual impact of therapy among Asian-American clients is gift giving. Gift giving demonstrates to clients the direct relationship between work in therapy and the alleviation of the problem.

Giving

In one way or another, clients often wonder how talking about problems to psychotherapists can result in the alleviation of emotional and behavioral distress. In response to clients' uncertainties, therapists often resort to explanations of the treatment process: Clients should not expect immediate resolution of problems, talking about emotional difficulties results in greater insight and control of these difficulties, alternative causes of action to alleviate problems may be generated, the sharing of problems with another person is often helpful, one can learn better ways of dealing with crises, etc. Explanations of treatment are intended to provide a rationale and to alter clients' expectations so that they fit the therapy process. In other words, we attempt to change their expectations to match our form of treatment. Such a strategy is needed to deal with clients who do not understand the treatment process. Nevertheless, explanations of therapy should be viewed as necessary but not sufficient to maintain the involvement and motivation of clients. Almost immediately, clients need to feel a direct benefit from treatment. (We have called this benefit a "gift" since gift giving is a ritual that is frequently a part of interpersonal relationships among Asians.) The therapist cannot simply raise the client's expectations about outcomes. Direct benefits must be given, almost immediately. These are needed because of the (1) high dropout rate from treatment, (2) need to demonstrate the achieved credibility of the therapist (and of therapy), and (3) skepticism over Western forms of treatment on the part of many Asian-Americans. Providing a gift is difficult, particularly in the initial session, since the therapist may be interested in gathering information for assessment purposes.

What kinds of gifts can be given in therapy? Depending upon the client and situation, the therapist can strive to provide certain benefits. For example, clients who are depressed or anxious will perceive gains in therapy if there is an alleviation or reduction of these negative emotional states. For clients in a state of crisis and confusion, the therapist frequently helps clients to develop cognitive clarity or a means of understanding the chaotic experiences these clients encounter. Such a technique is often used in crisis intervention. Sue and Morishima (1982) have advocated normalization in work with Asian clients. Normalization refers to a process by which clients come to realize that their thoughts, feelings, or experiences are common; many individuals encounter similar experiences. The purpose is not to deny unique experiences or to make trivial the client's problems. Rather, it is intended to reassure clients who magnify problems and who are unable to place their experiences in a proper context because of a reluctance to share thoughts with others. Gift giving does not imply short-term treatment or even the necessity of finding quick solutions. However, it does imply the need for attaining some type of meaningful gain early in therapy. The process of giving, of course, can be conceptualized as a special case of building rapport or establishing a therapeutic relationship. One central argument is that therapists focus on gift giving and attempt to offer benefits from treatment as soon as possible. Therapists should think of the gifts that can be offered, even in the first session. Table 2 shows some of the gifts that the therapist can offer.

In our analysis of the importance of credibility and giving, several features are apparent. First, the concepts of credibility and giving are not new. What we have tried to do is to argue their relevance particularly for Asian-Americans. They should be the initial focal point of therapists. It may be wise to address some questions. What is my level of ascribed credibility with this client? How can I enhance my ascribed/achieved credibility? What kind of gift is important to provide? How can I offer this gift? Second, the two concepts are not limited to any particular therapeutic orientation. They cut across different approaches

Table 8-2. Immediate benefits in therapy

1. anxiety reduction
2. depression relief
3. cognitive clarity
4. normalization
5. reassurance
6. hope, faith
7. skills acquisition
8. coping perspective
9. goal setting

such as Gestalt, psychoanalytic, client-centered, and behavioral treatment. Third, credibility and giving are viewed as necessary but not sufficient ingredients for positive treatment outcomes. Long-term client changes are influenced by other therapist, client, and situational factors. However, we believe that the mental health profession in its attempts to find effective means of treatment has lost sight of some basic processes that are crucial. Most investigators have focused on distal considerations (e.g., knowledge of culture or structured therapy relationships) rather than on the processes that underlie these considerations. Fourth, credibility and giving are more concrete than notions of cultural responsiveness, match or fit, therapeutic flexibility, cultural sensitivity, etc. They may provide better and more specific targets for our training efforts. Cultural knowledge is necessary but if we have not erred, it is in the direction of ignoring therapeutic processes in favor of abstract admonishments to know culture. A balance between the two is needed.

CASE EXAMPLE

Let us present a case of a client and then raise issues concerning credibility and giving. It is taken from Sue and Morishima (1982, pp. 76-77). We have selected this case, not because it neatly illustrates the processes of credibility and giving, but because the treatment raised issues relevant to the process.

> At the advice of a close friend, Mae C. decided to seek services at a mental health center. She was extremely distraught and tearful as she related her dilemma. An immigrant from Hong Kong several years ago, Mae met and married her husband (also a recent immigrant from Hong Kong). Their marriage was apparently going fairly well until six months ago when her husband succeeded in bringing over his parents from Hong Kong. While not enthusiastic about having her parents-in-law live with her, Mae realized that her husband wanted them and that both she and her husband were obligated to help their parents (her own parents were still in Hong Kong).
>
> After the parents arrived, Mae found that she was expected to serve them. For example, the mother-in-law would expect Mae to cook and serve dinner, to wash all the clothes, and to do other chores. At the same time, she would constantly complain that Mae did not cook the dinner right, that the house was always messy, and that Mae should wash certain clothes separately. The parents-in-law also displaced Mae and her husband from the master bedroom. The guest room was located in the basement, and the parents refused to sleep in the basement because it reminded them of a tomb.
>
> Mae would occasionally complain to her husband about his parents. The husband would excuse his parents' demands by indicating, "They are my parents and they are getting old." In general, he avoided any potential conflict; if he took sides, he supported his parents. Although Mae realized that she had an obligation to his parents, the situation was becoming intolerable to her.

Mae's ambivalence and conflict over entering psychotherapy were apparent. On the one hand, she had a strong feeling of hopelessness and was skeptical about the value of treatment. Mae also exhibited an initial reluctance to discuss her family problems. On the other hand, she could not think of any other way to address her situation. Then, too, her friend has suggested that she see me since I (Sue) had experience with Asian-American clients. In retrospect, I realize that my ascribed credibility with Mae was suspect. I was an American-born Chinese who might not understand her situation; furthermore, her impression of psychotherapy was not positive. Mae did not understand how "talking" about her problem could help. She, as well as her close friend, was unable to think of a solution and she would doubt how a therapist could help. My age was probably an advantage--too young to be considered a parental figure (who might be an ally of her parents-in-law) and old enough to have had experience in working with clients. The gender difference did not seem to matter. In such a situation, achieving credibility is critical. I wanted to demonstrate that I understood her conflict and would not adopt the position of her in-laws. Attempts were made to reflect her feelings and to occasionally summarize her conflicting feelings over (1) anger at in-laws for their demands (and husband for not helping her) and (2) failure to act as an ideal daughter-in-law and wife in fulfilling obligations. These attempts were somewhat successful as judged by her progressive openness in detailing her problems and by her emotional reactions (e.g., crying) when summaries of her problems were verbalized to her. Unlike many Asian-Americans, Mae seemed willing to self-disclose as long as I did not do anything to reduce my credibility. That is, the task was to avoid mistakes rather than to find means of drawing her out. Toward the end of the first session, I also wanted to provide Mae with some gifts--reassurance and hope. I indicated conflicts with in-laws were very common especially to Chinese who are obligated to take care of parents. An attempt was made to normalize the problems since she was suffering from a great deal of guilt over her perceived failure to be the perfect daughter-in-law. I also conveyed my belief that in therapy we could try to generate new ideas to resolve the problem--ideas that did not simply involve extreme courses of action such as divorce or total submission to the in-laws (which she believed were the only options).

I discussed Mae during a case conference with other mental health personnel. Interestingly, many suggestions were generated: Teach Mae how to confront the parents-in-law; have her invite the husband for marital counseling so that the husband and wife could form a team in negotiating with his parents; conduct extended family therapy so that Mae, her husband, and her in-laws could agree upon contractual give-and-take relationships. The staff agreed that working solely with Mae would not change the situation. However, these options entailed extreme response costs. Confronting her in-laws was discrepant with her role. Trying to involve husband or in-laws in treatment was ill-advised. Her husband did not want to confront his parents. More importantly, Mae was extremely fearful that her family might find out that she sought psychotherapy. Her husband as well as her in-laws would be appalled at her disclosure of family problems to a therapist who was an outsider.

We are not implying that these strategies would have failed. There is no a priori way of knowing their effectiveness. What is known is that Mae would have found unacceptable these means for resolving the problem. Urging her to adopt these strategies might have reduced the credibility of the therapist ("he does not understand Chinese role relationships, he is not aware of the situation, etc.") and resulted in her termination of treatment.

How can Mae's case be handled? During the case conference, we discussed the ways that Chinese handle interpersonal family conflicts. These conflicts are not unusual to see. Chinese often use third-party intermediaries to resolve conflicts. The intermediaries obviously have to be credible and influential with the conflicting parties.

At the next session with Mae, I asked her to list the persons who might act as intermediaries, so that we could discuss the suitability of having someone else intervene. Almost immediately, Mae mentioned her uncle (the older brother of the mother-in-law) whom she described as being quite understanding and sensitive. We discussed what she should say to the uncle. After calling her uncle, who lived about 50 miles from Mae, she reported that he felt that he should visit them. He apparently realized the gravity of the situation and wanted to help. He came for dinner, and Mae told me that she overheard a discussion between the uncle and Mae's mother-in-law. Essentially, he told her that Mae looked unhappy, that possibly she was working too hard, and that she needed a little more praise for the work that she was doing in taking care of everyone. The mother-in-law expressed surprise over Mae's unhappiness and agreed that Mae was doing a fine job. Without directly confronting each other, the uncle and his younger sister understood the subtle messages each conveyed. Older brother was saying something is wrong and younger sister acknowledged it. After this interaction, Mae reported that her mother-in-law's criticisms did noticeably diminish and that she had even begun to help Mae with the chores. Our intent in presenting Mae's case is not to illustrate the appropriateness or inappropriateness of certain techniques. The purpose is to demonstrate how credibility and giving should be relevant processes to consider in working with Asian-Americans.

In summary, research has been successful in bringing to the fore the difficulties in providing mental health services to Asian-Americans. It has been less than effective in identifying important processes in treatment as well as the translation of these processes for training purposes. We believe that therapist credibility and giving are important processes that have implications for treatment and training.

IMPLICATION FOR TREATMENT

It could be argued that credibility and giving are important in working with any client; so why emphasize these in the treatment of Asian-American individuals? Granted, credibility and the importance of giving are salient issues even with a Caucasian client who is naive about or distrustful of psychotherapy. However, such issues are dealt with in a sociocultural context in which the client and therapist frequently share common values, attitudes, norms, patterns of communication, and language. This situation is less prevalent for many Asian-American or ethnic minority clients. Outcome in therapy is the *cumulative* product of many discrete dynamics between client and therapist. For example, we doubt that an Asian client prematurely terminates solely because he or she may be ashamed of seeking help or is unfamiliar with psychotherapy. He or she leaves after a series of frustrations, misunderstandings, disappointments, as well as defensive reactions on the client's part that combine to create a poor response to treatment. The combination of language problems, role ambiguities, misinterpretations of behavior, or differences in priorities of treatment that may occur can produce a rapidly accelerating negative process in therapy for many Asian clients. Viewed in this context, credibility and gift giving become even more important because they can either exacerbate or help reverse this process.

Although it would be ideal to maximize both credibility and giving in treatment, our clinical experience suggests a more realistic objective in working with Asian clients: To minimize problems in credibility while maximizing gift giving. In essence, ascribed credibility and the three aspects of achieved credibility can be seen as marker areas for potential cultural problems in therapy. Gift giving, on the other hand, represents a potential positive force in treatment. In this manner both cultural problems as well as constructive solutions become salient foci in treatment.

Minimization of cultural problems does not imply that treatment should always match cultural expectations and norms. The primary purpose of therapy is to provide clients with new learning experiences. Often these involve prescriptions that run counter to cultural beliefs and/or accepted patterns of behavior. For example, a therapist working with a depressed Asian woman may want her to become more self-disclosing especially in expressing her feelings about certain problems she is having with her husband. Given that extensive self-disclosure of negative feelings and the focus on negative thoughts are culturally incongruent means of problem solving for the client, the therapist must decide whether this decrement in credibility is offset by other perceived gains in treatment. A gift may involve agreeing to help the client arrange for an intermediary to talk with her husband similar to Mae's case. The point is, cultural incongruities are often unavoidable and at times are necessary. However, by attending to issues of credibility and giving, therapy proceeds in a more systematic manner of handling these incongruities with an emphasis on producing constructive benefits, that often offset their adverse impact when it occurs.

IMPLICATION FOR TRAINING

Culturally responsive problem conceptualization, means for problem solving, goals for evaluating progress, and gift giving represent specific, clinical tasks that must be undertaken in the treatment of Asian-American clients. Training can be conceptualized as a program for developing skills in each of these areas. In this way, the diffuse concept of cultural sensitivity is transformed into a set of meaningful operational objectives for the development of skilled therapists.

By using this model, it becomes apparent why simply imparting knowledge of different cultures has been insufficient in the past. Such knowledge often involved very general and abstract concepts. More importantly, few training programs offered explicit guidelines for the application of these concepts to the specific clinical tasks of therapy. The type of cultural knowledge needed (e.g., values and help-seeking attitudes) varies depending on the clinical task at hand. For example, knowledge of general values is probably more important for the formulation of the clinical problems rather than the selection of the means for solving the problem. There is a need to develop specific types of knowledge and skills for the specific purposes of treatment. Table 3 lists a possible scheme for categorizing such information.

Finally, programs and therapists can be evaluated in each of these areas. Unfortunately, specific criteria for such an evaluation remains to be developed. A first step in this direction would be to assess client satisfaction in each area as opposed to the broad satisfaction dimensions traditionally measured. Trainees working with clients can be videotaped and evaluations can be made of credibility and gift giving skills; or therapist-client, role-playing situations can be created whereby the person adopting the role of client can provide the therapist-trainee with feedback on these skills. We have reached a point where innovative training practices must be found if we are to respond to ethnic minority groups.

Table 8-3. Operational objectives for culturally responsive therapy

	Required types of cultural knowledge	Required clinical skills
Conceptualization	general values family structure relationship norms (e.g., loss of face, amae, filial piety, obligation)	interpretation of values ability to explain problems in manner that client understands appropriate role observance
Means for problem-solving	attitudes toward mental health help-seeking attitudes attitude toward self-disclosure normative modes of coping with stress social support systems and relation attitude toward professional helpers	generation of adequate number of treatment options decision analysis ability to take client's role in solving problem.
Goals for evaluating progress	time perspective attitude toward self-growth attitude toward social rehabilitation survival concerns	contract-setting assessment of reinforcers and aversive stimuli in environment interviewing collaterals of client
Gift giving	how others see change in client norms for signifying change in behavior and attitude valued areas of behavior change	anxiety reduction crisis reduction family mediation communication problem-solving reframing

In terms of specific recommendations for curriculum and practicum training, four considerations are important:

1. Aquisition of cultural knowledge. Trainees should be exposed to literature, seminars, courses, and guest lecturers that provide knowledge of the cultures and experiences of various Asian-American groups. By gaining knowledge of culture, trainees can have a context with which to view their clients and can examine the relevance of cultural factors for particular clients.

2. Appreciation of within-group heterogeneity. Discussions of Asian-American culture should always be tempered with an appreciation of within-group differences. Various Asian groups (e.g., Chinese, Japanese, Koreans, and Pilipinos) differ from each other; marked differences can be noted even within a single Asian group. The nature of these differences should be learned.

3. Experience with Asian-Americans. Actual experience with Asian-Americans is critical in helping trainees to translate their classroom knowledge into direct helping skills. Learning about a group is then accompanied by actual contact, and stereotypes may diminish as a result of exposure to a variety of Asian-Americans.

4. Credibility and gift-giving skills. As previously mentioned, it is important for trainees to develop skills in enhancing credibility and gift giving. Training programs should systematically assess trainees' level of credibility and gift giving and should find means to increase these skills.

While programs often include certain features of these four aspects in their training, it is vital that these four aspects be systematically and thoroughly integrated, if we are to truly respond to Asian-Americans and other ethnic groups.

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CHAPTER 9

MENTAL HEALTH SERVICES IN ASIAN AND PACIFIC AMERICAN COMMUNITIES: DIRECTIONS FOR TRAINING PROGRAMS AND CURRICULA

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A decade has passed since the first formulation of training program and curriculum recommendations for mental health services to Asian and Pacific American communities (Kuramoto 1971, Murase 1972, Gaw 1975, Kushida 1976, Sue and Chin 1976, Dong et al. 1978, Wong 1978). Developments during this decade in mental health services training based upon research and on practices are documented for the core mental health professionals in psychology (Wong et al. 1983), psychiatry (Wong et al. 1983), social work (Kuramoto et al. 1983), and psychiatric nursing (Fujiki et al. 1983). Since existing works have defined and documented the extent of mental health services and severity of training issues for Asian and Pacific Americans, those findings will not be repeated in this chapter. Rather, the state of the art is reviewed with respect to the delivery of mental health services to Asian and Pacific Americans, as well as the implications of clinical practice findings for training programs and curricula. Following the definition of this ethnic minority group, several cautionary considerations and a statement of our value orientation to training, we will develop a conceptual model for viewing training programs for Asian and Pacific Americans. A review of existing community mental health programs that highlights strategies for enhancing service delivery and for developing culturally sensitive programs follows. Factors that enhance culturally sensitive mental health services and the implications for training programs and curricula are presented. Finally, current gaps and new directions in services and training, along with recommendations for training programs for Asian and Pacific Americans, are provided.

DEFINITION OF "ASIAN AND PACIFIC AMERICANS"

The phrase "Asian and Pacific Americans" is actually a contraction of two terms, "Asian Americans" and "Pacific Island Peoples." It is borrowed from the convention developed by the Special Population Subpanel on the Mental Health of Asian and Pacific Americans of the President's Commission on Mental Health (1978). Although used throughout this chapter, "Asian and Pacific Americans" is in fact a convenient summary label for a very heterogeneous group. There certainly is not universal acceptance of this labeling convention, but for practical purposes it has been adopted frequently, with occasional variations (for example, "Asian/Pacific Americans," "Pacific/Asian Americans"). It represents the self-designation preferred by many Asian and Pacific people in the United States.

"Asian and Pacific Americans" refers to a constellation of people from a number of ethnic and cultural backgrounds who had, in the past, been designated simply as "other" (Wong 1979). At least 32 distinct ethnic and cultural groups might meaningfully be listed under this designation: Bangladeshi, Belauan (formerly Palauan), Bhutanese, Burmese, Chamorro (Guamanian), Chinese, Fijian, Hawaiian, H'mong, Indian (Asian or East Indian), Indonesian, Japanese, Kampuchean (formerly Cambodian), Korean, Laotian, Malaysian, Marshallese (of the Marshall Islands, which include Majuro, Ebeye, and the U.S. missile range, Kwajalein), Micronesian (of the Federated States of Micronesia, which include Kosrae, Ponape, Truk, and Yap), Nepalese, Okinawan, Pakistani, Pilipino, Saipan Carolinian (or Carolinian from the Commonwealth of the Northern Marianas), Samoan, Singaporian, Sri Lankan (formerly Ceylonese), Tahitian, Taiwanese, Tibetan, Tongan, Thai, and Vietnamese (Wong 1982).

The pooling of separate Asian American and Pacific Island groups under the label of "Asian and Pacific Americans" emerged in part out of political necessity. First, the summarizing term "Asian and Pacific Americans" is overly simplistic in representing diverse groups of people with very different histories, cultures, and languages. It becomes extremely complicated when we are involved in training individuals to provide mental health services to this population. In its development, one can see this aggregate minority group as an ever-emerging mosaic of diverse constituencies. Groups are added and removed based on self-definition and need for self-determination. To the extent that its members find enough commonalities in experiences, goals, needs, and visions, the collective is strengthened. To the extent that specific groups pursue individual goals and identities and otherwise accentuate differences, the collective is weakened. Thus, this alliance of diverse constituencies is at once a rallying point for action and an arena for divisional struggle when common goals or visions to guide collective action are lacking. In the past decade the pursuit of adequate mental health and other human services has provided a focus and opportunity for unified, collective action.

CAUTIONARY CONSIDERATIONS

First, the convenient summarizing term "Asian and Pacific Americans" simplifies too much the diverse groups of people with very different histories, cultures, and languages, especially when we are involved in training individuals to provide mental health services to this population. Even consideration of the 32 distinct ethnic groups as major subpopulations will result in ignoring vast differences within each of the groups along important dimensions such as (1) migration and relocation experiences; (2) rate of acculturation and assimilation; (3) family composition and family intactness; (4) area of residence in the United States; (5) native language facility; (6) identification with the "home" country; (7) comfort and competence with the English language; (8) degree of trauma in transition; (9) sense of rootedness; (10) education (years in Asia, in the United States, and elsewhere); (11) age; (12) social-political identification; (13) embeddedness in the local, regional, and national community networks (such as family associations, mutual assistance associations, and clubs); (14) religious beliefs and value orientations; (15) intergenerational intactness; (16) degree of dispersion of social and family network; and (17) work and vocational accomplishments and status. Sensitivity to the ethnic, cultural and linguistic diversity of Asian and Pacific Americans will be the key factor in providing successful mental health training, services, and treatment programs to these populations.

Second, mental health concepts and techniques as they exist in current practice are foreign to many of the Asian and Pacific American subgroupings, in particular recent immigrants, many of the Pacific Islands peoples, and Southeast Asian refugees. For example, clinical psychology and psychiatric social work as professions are almost unheard of in Southeast Asian countries. A school of social work was not established in Vietnam until 1972. Nguyen et al. (1980) noted that Vietnam had only six psychiatrists for its population of 16 million; the doctor-patient ratio in the nonmilitary population was 1 in 50,000 (Poffenberger 1971). For many Asian and Pacific Americans, mental health services and practices may be viewed in a negative light and with little understanding and appreciation of "talking treatment" and the value of "opening up" and self-disclosure. The qualities and conditions of mental well-being, emotional balance, and peace of mind are as important to this population as they are to anyone adhering to the Western concepts of maintaining "good mental health." However, the practices of Western psychotherapy and psychological practices may not be a preferred nor viable approach for achieving "mental health." Sensitivity to similarities in valuing "emotional balance, mental health and well-being," although the methods and practices for achieving such "health" are very different, is crucial to any program's provisional efforts. That is, in their home countries, personal and interpersonal problems are solved by relying on the leaders of the community, elders in the family, religious leaders, and other community support mechanisms. To the recent Asian and Pacific immigrants and refugees, what we view as professional interventions may appear to be the meddling of an "unwelcomed stranger" in one's midst. Training programs need to take into account the role of the "stranger" in mental health intervention (regardless of whether the provider is from that culture or not). Furthermore, the importance of preparing bicultural providers for client resistance related to the unfamiliarity and differences in perception of mental health problems is a key component of a training program.

Third, for many of the recent immigrants and especially the Southeast Asian refugees trained to be mental health providers, many have only recently (within a few years) experienced for themselves the traumas of relocation and resettlement. Treatment of mental health problems by these providers oftentimes requires them to handle many concerns related to experiences that they have only recently undergone or possibly may even be in the process of experiencing. Training programs need to be extremely cautious about the ramifications of such problematic exposure to their trainees and staff and the importance of providing ongoing supervision and support.

VALUE ORIENTATION AND APPROACH

It is the conclusion of this author and other writers in the training field (President's Commission on Mental Health 1978, Wong et al. 1983, Kuramoto et al. 1983, Wong et al. 1983, Fujiki et al. 1983, Sue and Morishima 1982, Nguyen et al. 1980) that the ideal provider of mental health services to Asian and Pacific American populations would be a professional provider with bilingual and bicultural expertise corresponding to the client's linguistic, cultural, and life experience background. As such, this author, in the writing of this chapter, reflects the value orientation and approach that quality and accessible mental health services to Asian and Pacific Americans are more effectively and best provided by trained bilingual and bicultural professional providers, especially emerging Asian and Pacific populations and Southeast Asian refugees. The goal of all clinical training funding strategies for serving these populations should be to ultimately produce a pool of trained bilingual/bicultural professional personnel.

Unfortunately, at least for this next decade, there is no way to achieve such a goal. Academically prepared and qualified bilingual/bicultural individuals who can enter such training are limited, and for emerging and refugee populations, such individuals scarcely exist. For example, many Pacific Island and Southeast Asian refugees are on the level of working on fulfilling their general education requirements toward a bachelor degree. Of those who are in post secondary educational training, many have career orientations in technical and business fields. Very few are interested in mental health and human services professions. For emerging Asian and Pacific populations, only a handful are in graduate mental health training programs in the United States.

As such, this chapter focuses on the diversity of training programs needed to meet the mental health services needs of Asian and Pacific Americans in this decade. Although we can state our ideal provider, the focus of this chapter is one of training bilingual/bicultural mental health providers from Asian and Pacific American cultural backgrounds, as well as those who are not from those backgrounds.

CONCEPTUAL MODELS FOR VIEWING TRAINING AND SERVICE PROGRAMS

A variety of conceptual models have been advanced for training professional and nonprofessional mental health providers for Asian and Pacific Americans (President's Commission on Mental Health 1978; Wong 1977, 1980, 1982; Chikahisa et al. 1980; Kushida et al. 1976; Murase 1976; Sue and Chin 1976; Dong et al. 1978; Wong et al. 1983; Kuramoto et al. 1983; Wong et al. 1983; Fujiki et al. 1983; Sue and Morishima 1982; Wong et al. 1982). Our conclusion, after reviewing all of the noted training models is that our preferred conceptualization for any training programs is one that enhances the fit between the Asian and Pacific American's needs and the mental health resources or interventions available from the provider. We advance this training and service conceptual model for viewing Asian and Pacific American training programs.

Client-Provider Fit Conceptual Model

A goodness-of-fit model involving the refugee's needs and the mental health service's resources is proposed to clarify individual-, group-, and system-level issues in the delivery of mental health services to Asian and Pacific Americans. Client or participant outcomes (such as improved psychological functioning, increased emotional well-being, continuation in treatment or satisfaction with services can be viewed as a function of the goodness of fit between the client's needs and the resources of the mental health system. From this perspective, the lack of success in service delivery to Asian and Pacific American populations is attributable to a poor fit between client systems and service systems. An adequate training program would allow trainees to enhance the client-provider fit.

Both clients and services are part of larger systems. The client system may include the individual, his or her immediate and extended family, community groups to which the client and family may belong, and other progressively encompassing structures. The mental health system includes a counterpart to each structure in the client system: the individual provider or clinician, the service unit, the agency, the service program, and so on. We will use this model in reviewing existing mental health service and training efforts to Asian and Pacific Americans and in sensitizing ourselves to issues of specific importance to this population. Where applicable, culturally appropriate alternatives will be highlighted.

First, we will identify existing reviews and recommendations for training and for service delivery. A variety of efforts and strategies have been employed to improve a client-service fit. The President's Commission on Mental Health (1978) offered 67 general recommendations for improving mental health services, research, and training, and for moving toward a better fit between needs and resources. The Commission's report is the single best source of comprehensive recommendations for improving services to Asian and Pacific Americans.

Other major sources of recommendations also exist. Means to improve the fit between the client system and the service delivery system was the topic of two recent regional conferences: "Recent Developments in Services to Multi-Ethnic Populations" sponsored by the National Institute of Mental Health (NIMH) Staff College (Wong 1984) and "Challenges for Asian/Pacific Mental Health" sponsored by the Asian Pacific Planning Council of Southern California (Wong 1983). Three national mental health research and service priority-setting conferences funded by NIMH addressed similar national issues. These were titled (1) "Pacific Island Conference: Prioritization of Mental Health Services Development for the Pacific Islanders" (Tseng and Young, 1981); (2) "Research Priorities for Mental Health Services for Asian/ Pacific Islanders" (Owan 1980); and (3) "Community-Involved Research for Pacific/Asian American Minority Groups" (Park 1980). Other sources of recommendations are (1) the four Asian American/Pacific American (AAPA) core discipline caucuses (psychiatry, psychology, psychiatric social work, and psychiatric nursing) at the national conference on "Training of Psychiatrists, Psychologists, Psychiatric Social Workers, and Psychiatric Nurses for Ethnic Minority Communities" sponsored by Howard University (1980); (2) key national consultants at the "Minority Mental Health Services Conference" sponsored by the Western Interstate Commission on Higher Education (WICHE) (1980); (3) the two national consultations to ADAMHA by the Asian and and Pacific Americans Consultant Group (Shon 1980) and the Indochinese Refugee Consultation Group (Nguyen 1980); (4) the Social and Human Service Panels at the "Asian/Pacific American National Leadership Conference: 1980--A Decade of Progress for Asian/Pacific Americans?" sponsored by the U.S.-Asia Institute (1980); and (5) testimony before the Civil Rights Commission on "Civil Rights Issues of Asian and Pacific Americans: Myths and Realities" (Lee 1979, Shon 1979).

Second, we would like to highlight strategic approaches that have been used to enhance service delivery and for developing culturally sensitive programs in Asian and Pacific American communities.

Training and supervision to enhance existing non-minority staff and services is a strategy that is usually employed in areas where bilingual and bicultural personnel tend to be scarce. Most often, an external consultant is brought in to conduct in-service type programs or a regional workshop is convened to pool expert consultants for major presentations. An example of this approach is the set of four regional workshops convened by NIMH in conjunction with the Office of Refugee Resettlement and the Office of Refugee Health in fiscal year 1983 to address some of the mental health treatment, prevention, and development needs of practitioners regarding cultural sensitivity in services to Southeast Asian refugees.

Augmenting existing programs with paraprofessional and bilingual translation support staff. In areas where bilingual and bicultural non-mental-health and nonprofessional personnel exists, this strategic approach has been workable, especially where professional supervision is available for these personnel. Usually this is a time-limited approach with the notion of hiring or developing bilingual professional personnel in future times. Examples of this approach are most often found in inpatient mental health settings where most of the existing professional staff are non-Asian and demand for services is relatively heavy by one or more Asian and Pacific American groups in the particular community. Joint efforts by the paraprofessional and his or her supervisor lead to cultural knowledge, mutual respect, and cultural sensitivity.

Augmenting existing programs with professional bilingual/bicultural consultant staff on an on-call or rotating basis. This approach is usually used in areas where Asian and Pacific

American populations are substantial but demand for mental health services is limited. An example of such an approach would be the psychiatric consultant who rotates among different Pacific Islands providing needed mental health services. Such work also includes providing case consultation and training to sensitize existing program staff of each area visited.

Developing Asian and Pacific American bilingual and bicultural parallel staffing and programming. This approach allows for the establishment of a mental health program to exist as a satellite or specialty center to an already established mental health program. Cultural sensitivity and knowledge are ensured by virtue of the staffing pattern and parallel program created. An example of such an approach is the establishment of the Richmond Area Multi-Services mental health services program in 1975 to address the needs of the Asian and Pacific community as parallel services to the existing city and county of San Francisco community mental health services program, which did not have the capacity to serve the Asian client population in the neighborhood.

Developing Asian-specific mental health programs and services. This strategic approach, like the former, ensures culturally sensitive and skilled staff and programs from the start (since they are so planned from the very beginning). Examples of such programs include (1) the Asian Inpatient Psychiatric Program of San Francisco General Hospital, (2) Asian Counseling and Referral Services of Seattle, (3) Asian Community Mental Health Services of Oakland, California, and (4) Asian/Pacific Counseling and Treatment Center of Los Angeles.

Developing Asian-specific multiservice programs in which mental health is a service component. This approach provides for the development of a large multiservices umbrella agency with many programs serving one or more Asian and Pacific American population. Mental health services is one of the many program components in such an agency. An example of this strategic approach is the South Cove Community Health Center in Boston's Chinatown, which is a comprehensive health center with school, housing, nutrition, social, and mental health services. In such an approach, the mental health program is fully integrated into the total services available to the community. Receptivity by community clients is very high.

Collaborating through coalitions, mutual assistance organizations, and consortiums for mental health services to a specific Asian and Pacific American community. For many emerging and newly arrived refugee or immigrant Asian and Pacific groups, culturally sensitive mental health programs are established by pooling resources as part of a larger consortium. An example of such an approach is Asian Human Services in Chicago. In order to establish mental health services for the Korean community in Chicago, a consortium of Asian and Pacific community agencies was formed to pool resources and to submit a comprehensive proposal.

In our review of strategic approaches to developing more culturally sensitive mental health services, the above-noted seven strategies appeared to account for almost all of the Asian and Pacific American program approaches. We will now turn to specific factors that we have distilled out of our ongoing practice of providing mental health services that would be important to training programs and curriculum development for Asian and Pacific American communities.

FACTORS RELATED TO CULTURALLY SENSITIVE PROGRAMS

INTERACTIVE AND COMMUNICATION PATTERNS

Western-trained providers are familiar with and are trained to interact with clients as "mental health professionals." For many Asian and Pacific Americans, the roles, structure, tempo, and content of initial and subsequent counseling sessions go completely against the interactive and communication patterns they are used to: Ayabe (1971) gives examples of voice quality and deference, Tsui (1985) provides examples of content and relationship dimensions, and Johnson et al. (1974) establish differences in verbal communication patterns. Training programs need to provide the kinds of supervision, training, and feedback to trainees that address previously established, individually developed interactive and communication patterns that can enhance culturally sensitive services.

BELIEF SYSTEMS ABOUT MENTAL HEALTH AND MENTAL ILLNESS

As noted by Lee (1982), Western-trained providers attend to intrapsychic influences on behavior, whereas Southeast Asian refugees and other Asian and Pacific Americans use such psychological explanations only rarely (Tung 1979). For example, Chinese immigrants believe that mental health is achieved through the exercise of willpower and the avoidance of morbid thoughts (Lum 1974). Sue et al. (1976) found similar results for Japanese and Filipino Americans, for whom good mental health was perceived as being a result of the avoidance of morbid thoughts. Lee (1982) and Tung (1979) note a wide range of common etiological beliefs among Chinese and Southeast Asians including: organic disorders, supernatural intervention, genetic vulnerability or hereditary weakness, physical or emotional exhaustion caused by situational factors, metaphysical factors such as the imbalance between yin and yang, fatalism, and character weakness. Such differences in belief systems about health and illness by clients often necessitate special efforts on the part of the provider to ensure acceptability of services. Training programs for mental health providers, of necessity, need to familiarize the practitioners with such concepts and belief systems.

Stigma and Shame

As noted by Shon and Ja (1982), "the concepts of 'shame' and 'loss of face' involve not only the exposure of one's actions for all to see, but also the withdrawal by the family, the community, and the society of their confidence and support." In the seeking of mental health services, not only personal shame but also personal and family stigma come into play. Training programs need to prepare the potential provider with skills and guided experiences in community education and communication efforts as well as client outreach efforts (such as services in the home) in order to reduce stigma and shame in Asian and Pacific Americans.

Family Structure and Reactions to Mental Illness

In Eastern cultures the family rather than the individual is considered the unit of focus and identity. Asian and Pacific American clients tend to view themselves as members of an extended family with strong emphasis on family obligations, mutual dependency, and collective responsibilities and decisionmaking. As noted by several authors (Tung 1972, 1979, 1980; Lee 1982; Shon and Ja 1982), the family structure and the family's reaction to mental illness may have much greater impact on any family member seeking and continuing with mental health treatment than the individual's inclination to pursue treatment. Consideration of the Asian and Pacific American family has been noted as critical in ensuring client participation. Training programs need to provide skill development in areas such as cultural orientation to the importance of family dynamics, family education regarding the mental disorders of one or more of its members, and culturally syntonic family therapy methods.

Patterns of Help Seeking

For reasons related to their more holistic view of health and other cultural traditions, Asian and Pacific American clients tend to exhibit patterns of help seeking that emphasize self-help and natural community resources as alternatives to mental health services. These include physical health care and other human services instead of, or as a pathway to, mental health services (Tung 1979, 1982; Lin et al. 1979; Leong 1982; Lee 1982); family and friends, herbalists, acupuncturists, and other indigenous healers are all utilized both before and concurrent with mental health treatment.

Lee (1979, 1982) using data from clinical case materials from the mental health treatment of Chinese Americans (including ethnic Chinese from Vietnam) traces the pathway of service alternatives, programs, and agencies. Over a dozen alternatives were tried and repeated before use of the mental health system. Clients may use family and relatives, willpower and self-action, social service providers (such as teachers of English-as-a-second-language or translators), instructive readings, informal friendship networks, herbalists, other indigenous healers/helpers (such as martial arts masters), ministers and priests, providers in a health clinic, general practitioners, or specialists in medicine. Mental health services are likely to be the last alternative tried. The ability of mental health providers and programs to identify and collaborate with the full range of caregivers is critical to effective referral, entry, and continuation in treatment. Consultation and education activities with referral sources are also important (Lum 1981, Lew and Zane 1981). Training programs need to provide some focus on the indirect services aspect of mental health care for their trainees.

Culturally Specific Models and Practice of Health Care

There are differences not only in help-seeking behaviors, but also in underlying models of health care. Specific community models can include traditional and folk-healing methods (for examples see Kleinman and Lin 1981, Tseng and Young 1981); perception of specific Western practices as effective or ineffective (such as the Vietnamese view of injection as more effective than oral ingestion of medication); and expectations about the roles, functions, and treatment practices of providers. As mentioned earlier, training for providers to overcome the issues of the "stranger" as helper and the resistance of clients as a result of the unfamiliar role of the provider is necessary.

Community Support, Linkage, and Acceptability

For Asian and Pacific American populations, the community provides the arena for interaction and exchange; thus, it is not uncommon to see in large urban areas the concentration of Chinese, Korean, Japanese, Filipino, Vietnamese, Cambodian, Lao, and H'mong in specific areas of the cities (for example, Chinatown, Japantown or the Tenderloin Area in San Francisco, Koreantown and Japantown in Los Angeles, and the Chinatown Area in Boston. Since mental health concerns and mental illness are still quite stigmatizing to the individual (and the family), the community's reaction to them plays a critical role in whether clients seek and continue treatment. Program planners and providers must engage community members and leaders in developing support for and acceptability of mental health services within the refugee community. Training programs that teach skills needed to develop community support and acceptability are critical.

Degree of Acculturation

Several studies (Conner 1974, Kikumura and Kitano 1973, Masuda et al. 1970, Meredith and Meredith 1966) have noted the greater similarity to Caucasian personality characteristics and the adoption of white American values by Asian-Americans who have become more assimilated or acculturated into mainstream America. The greater the assimilation, acculturation, or biculturality, the more likely that such individuals will find Western-oriented mental health services acceptable and appropriate. Lee (1982) has indicated four variables that are related to acculturation: years in the United States, country of origin (more Western-like countries of origin make for easier transitions), professional affiliation and status, and age at immigration. To the extent that individuals remain unassimilated, special efforts must be made via such channels as mental health education and information programs and pretherapy orientation to ensure a good match between expressed needs for services and the actual mental health services available. Especially for refugees and newly arrived immigrants, the request for mental health services may be instigated by some third party--a school counselor, a family court, or a public health nurse, for example. An accurate assessment must be made of the client system as to the degree of acculturation and extent of receptivity and understanding of mental health treatment. Training in making such assessments is of major importance.

Religion

Although a large variety of religions or philosophical systems, Western or Eastern, can be said to be prevalent with Asian and Pacific Americans, both Western religions (such as Catholicism and Protestantism) and Eastern religions (Buddhism, Taoism, Confucianism) are practiced, depending on the degree of assimilation and acculturation to the West. In some religions priestly functions and roles are associated with a self-disclosing, confessional quality inherent in verbal therapies. However, in other Eastern religions the qualities of endurance, self-sacrifice, and personal suffering are admired and fostered. Strong belief in such qualities results in a stance completely at odds with the verbal expressiveness of Western modes of treatment. Thus, the client's religious belief system can have a significant effect on the client's view of and participation in mental health services.

Language

In arenas of work in which small nuances of speech can carry major differences in surplus meaning and connotation, language is clearly an important consideration. If a provider does not speak the language (or the particular dialect) of the client, the client-provider gap can be tremendous. The gap can be widened by differences in socioeconomic class, educational level, sociopolitical identification (such as coming from North or South Vietnam), age and sex, generational status in the United States, and vocational-professional standing. Linguistic, structural, and lexiconal variations in the different Asian and Pacific languages provide the native speaker (most often the client) with subtle but specific cues about the provider and the nature of the treatment relationship. Few alternatives exist in the mental health treatment of monolingual or English-limited clients to language proficiency on the provider's part. The use of a translator for services may be necessary, but this only provides rough approximations to the expressed meanings of the client. Language gaps represent one of the most difficult barriers to adequate services for Asian and Pacific American clients. To a large extent, language constitutes an untrainable area to non-native speakers when it comes to mental health treatment.

Cost

Refugees are usually not covered by medical insurance or other third-party benefits. At the same time, cultural values governing obligations and self-sufficiency may result in conflict within families over participation in financially assisted services in which fees are not collected. Moreover, for many Asian immigrants (those who are sponsored to the United States, and are not admitted as "refugees") who may want to achieve permanent legal status as residents in the United States, participation in a government-supported service, usually Medicaid or Medicare, may be at odds with their goal, because immigrants must be family sponsored, and therefore not in receipt of federally sponsored benefits. Training for effective and sensitive handling of issues of cost determination and ability to pay constitutes a significant element in successful service delivery.

Perceived Responsiveness of Services

It is important for the actions of "gatekeepers" in the mental health setting to know how to convey a sense of acceptance and willingness to help. For Asian and Pacific Americans, the perception of responsiveness can be enhanced by various measures: (1) an acceptable name for the facility, (2) the general appearance and upkeep of the facility and waiting areas, (3) bilingual assistance on the first telephone call, (4) friendliness of reception personnel, (5) a pre-first-session confirmatory telephone call, (6) a postsession followup call, (7) willingness of providers to assist in other functions besides mental health services (such as translation services), (8) the taking of a more informal and less professional role, and (9) willingness of the provider to share information about himself or herself. One of the clearest indicators of responsiveness for monolingual or English-limited refugee clients on encountering the mental health system is a staff that can speak to them in their primary language. To improve perceived responsiveness, an effective procedure is client-flow/client-entry system evaluation to identify practices associated with varying utilization. For providers who are not of the Asian or Pacific cultures, training procedures involving role playing and simulation of initial sessions with Asian and Pacific providers have been important toward sensitizing individuals to actions and nuances that come across as responsive to refugee client care.

Location and Knowledge of Facilities

Kim (1978), in her study of Chinese, Japanese, Korean, and Filipino Americans in the Chicago area, found that for a significant number of Asian Americans, especially immigrants and women, a primary reason for not seeking help was not knowing where to go. Clients' lack of knowledge of service facilities can be corrected by public service announcements, community education, advertisements, and other public relations activities. Problems related to location, given the need to serve a dispersed population, are not so easily overcome. For example, Sue and

Morishima (1982) note that in the Seattle area, Asian clients may have to travel over 100 miles before they can use the Asian Counseling and Referral Services. In Los Angeles, clients encounter similar or greater travel distances to use the Asian/Pacific Counseling and Treatment Center. Another barrier for Asian clients is that of the catchment or service area restrictions limiting who can be served. Since many Asian and Pacific Americans are spread much wider than one catchment or service area, their participation in one specialized mental health program, with its concentrated resources, is problematic. Training that fosters a positive attitude toward clients who come from very disperse areas is important for effective services to the refugee population.

Hours of Operation and Client/Family Work Schedules

Asian families, especially immigrants and refugees, tend to have extended work hours (sometimes two or more jobs) and multiple family members at work. Very few can get release time to utilize mental health services during normal office hours. To ensure accessibility, flexible scheduling - usually around father's day off for families--and evening or weekend hours may be necessary. For non-Asian providers, sensitivity to the usual Western notions of time and fixed appointments becomes an important aspect of training to enhance a better fit of client's time orientation to those of the provider's.

CONCEPTUALIZATION AND ASSESSMENT OF CULTURAL COMPETENCE IN CLINICAL PRACTICE

We have provided a set of factors that can enhance the delivery of mental health services and provide greater perceptions of cultural sensitivity by recipients. Three conceptual approaches have guided our efforts to develop greater cultural competence in clinical practice: (1) provide cultural information to enhance cultural sensitivity of providers; (2) provide skills training and supervision in select areas to enhance cultural-related clinical skills of provider; (3) select bilingual/bicultural individuals and train them in mental health services and allow them to infuse their mental health practice with ethnic-appropriate behaviors and actions.

At this point, there are three critical questions that are unanswered: (1) What aspects of cultural competency are trainable? (2) What aspects are a function of life experiences only? (3) What aspects of cultural sensitivity are substitutable with clinical skills? Assessment of cultural competence rests on first identifying those aspects with the source of competency development. For example, if bilingual/bicultural competence is a function primarily of life experiences (as is true for language ability), then we need to figure the best way to select for those qualities rather than to figure out how to train for them. On the other hand, if a skill is trainable or is amenable to change due to additional information, then we need methods to define, teach, and to evaluate the skills. Research is needed in this area to further our current state of knowledge.

RECOMMENDATIONS

The report of the Special Populations Subpanel on Mental Health of Asian and Pacific Americans (1978) and the Report of the Consultants to ADAMHA (Shon 1980) provide the two best sources for comprehensive recommendations on mental health training and services to Asian and Pacific Americans. Rather than repeat those recommendations, I refer the interested reader to those reports. I would like to highlight seven recommendations of major importance: (1) implement significant participation of Asian and Pacific Americans on all levels of decisionmaking and of program implementation for programs affecting the training of Asian and Pacific people, (2) effect adequate coordination and collaboration among the multiple training and service efforts, (3) emphasize ongoing consultations with government agencies relative to Asian and Pacific American training programs, (4) allocate funding to training programs for bilingual/bicultural professional and nonprofessional personnel, (5) encourage mobile and flexible bilingual/bicultural service teams in training and in service settings, (6) support prevention intervention training programs, and (7) support community-based, ethnic operated programs for training and service consortiums to Asian and Pacific Americans.

Finally, the following strategies and models are advanced for mental health training programs: (1) augment existing mental health training services, personnel, and programs with additional bilingual/bicultural providers; (2) create a parallel training program specifically for Asian and Pacific American bilingual/bicultural trainees; (3) create a special umbrella organization containing multiple service and training programs; and (4) support and fund community associations, coalitions, and consortiums to establish a national or regional mental health training center in an area with a high concentration of Asian and Pacific American communities.

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CHAPTER 10

CROSS-CULTURAL APPROACHES TO SERVICE DELIVERY TO ETHNIC MINORITIES: THE MIAMI MODEL

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The Community Mental Health Centers Act, which was passed by Congress in 1963, attempted to address accessibility of services nationwide. Proponents of the Act advocated geographical and cultural accessibility. As centers developed, data on utilization rates by major racial groups were obtained. It became apparent that ethnic minority groups were underutilizing the centers. The literature has noted that "underutilization" was linked to unacceptable or ineffective therapeutic effort, and that one of the critical factors was the experiential and cognitive distance between the typical white, middle class mental health professional and the typical catchment area client (Padilla et al. 1975).

With the expansion of mental health service delivery to low-income and multiethnic populations an abundant body of literature has emerged, suggesting that standard preventive, diagnostic, or therapeutic modalities may not always be relevant or effective in treating such groups. Studies of mental health professionals in interaction with clients from different ethnic cultures have indicated a wide range of difficulties. These include (among others) linguistic barriers in evaluating psychopathology (Marcos et al. 1973); underrecording or misinterpretation of symptoms (De Hoyos and De Hoyos 1965); serious diagnostic errors in observing behavior (Simon et al. 1973); failure to understand differential response patterns on screening instruments (Gynther 1972); basic communication difficulties and bias in interviewing (Carkhuff and Pierce 1967, Williams 1964); misinterpretation of psychodynamics (Thomas 1962); advice that is counter to cultural mores (Abad and Boyce 1974, Lombillo and Geraghty 1973); and failure to differentiate between adaptive and maladaptive behavior (Gilbert 1974).

This literature has focused mainly on deficits in our current modalities, with the vague, nonspecific conclusion that diagnosis and treatment become more "culturally appropriate." However, guidelines for what is culturally appropriate are few and far between. With a few rare exceptions (e.g., Pedersen 1973); admonitions that one must understand a client in terms of social and cultural context have not been accompanied by constructive suggestions on experiential, didactic, or training techniques.

Unless the practitioner is of matching ethnicity to the client, or has a firm familiarity with the client's background, "culturally appropriate" treatment often becomes a generalized application of bits and pieces from the social science literature and the media, and a memory bank of learned stereotypes. In some cases, this application of undifferentiated information by the overcompensating clinician may be as damaging as cultural insensitivity (cf. Fibush 1965).

This paper focuses on the development of a community mental health center that emphasized cross-cultural approaches to service delivery. In describing the project, the discussion will focus on the development of the agency, mental health approaches and cultural dimensions and training projects.

DEVELOPMENT OF THE PROGRAM

In a multicultural community such as the one in Miami, the range of mental disorders and the manner of presentation of these disorders is wide. Perception of illness and presentations of symptoms vary from one cultural group to the other. This variation poses considerable problems for traditional health institutions that are involved in the delivery of mental health care. The Department of Psychiatry of the University of Miami developed a research project to study and understand these cross-cultural differences in health beliefs and practices. This research--the Health Ecology Project funded by the Common Wealth Fund of New York in 1971, under the direction of Dr. Hazel Weidman--focuses on five major ethnic groups in the northwest area of Miami. These groups: Cubans, black Americans, Haitians, Puerto Ricans, and Bahamians were selected because they either (1) represented a major numerical proportion of the inner-city population and/or (2) tended to cluster in discriminable ethnic enclaves, constituting a valid and identifiable "community" and requiring a culturally appropriate approach to mental health care.

In this study of over 500 families, a battery of instruments was administered in each group by indigenous, ethnically matched research assistants, who maintained longitudinal contact with the families for ongoing indepth interviewing. Instruments included a comprehensive sociological questionnaire, symptoms and conditions list, values scale, and a health calendar maintained daily by sample families. At the end of the investigation of health beliefs and practices within these 500 families, the fieldworkers spent nine months interviewing folk healers and their patients from each ethnic group.

As part of the research effort, overlay maps had been developed showing the distribution and accessibility of supportive resources such as religious, medical, social service, and recreational facilities. The availability of folk healers, botanicas, unorthodox religious systems, and other resources involved in the supportive infrastructure were also delineated. Concomitantly, an ethnic library was established, and sets of files for each ethnic group were developed, which contained materials from the social science literature, unpublished papers, newspaper articles, demographic data, and other relevant information. These demographic and cultural materials facilitated interpretation of the research findings as they evolved.

The Health Ecology Project found that, although this area had a large number of social service institutions, they were being significantly underutilized. This underutilization stemmed from the lack of bilingual staff for the multiethnic, multicultural population. Further factors included lack of people's awareness of the programs, lack of transportation to access them, distrust of programs, and culturally determined attitudes conflicting with the backgrounds of residents.

The preliminary findings of the Health Ecology Project also indicated culturally patterned differences in perceptions of the prevention, causation, and remediation of illness, including mental illness. Health calendars, maintained daily by sampled families, indicated a high degree of emotional stress and numerous emotional problems for which orthodox mental health treatment was not solicited. These findings suggested that a community mental health center established along traditional lines would be ineffective in preventing or ameliorating breakdown, or in providing clinical resources that would be culturally appropriate and optimally utilized. What was needed was a new approach using community-based ethnic teams possessing the knowledge and experience to deal with mental health problems in a community and cultural context.

The Community Mental Health Services (CMHS) model thus evolved from a core of empirical research findings. In addition, Dr. James Sussex, Chairman of the Department of Psychiatry, University of Miami and Division of Mental Health at Jackson Memorial Hospital and four others who had been functioning as "cultural brokers" at the interface of the hospital services and the community, three anthropologists and a social psychologist who was already on the Department of Psychiatry staff, also had important input in program development. For periods ranging from a few months to a year, these social scientists had been active in the Psychiatric Institute in a teaching, consultative, and collaborative role with respect to patients from the specific ethnic groups. In addition to their role as cultural interpreters for mental health professionals dealing with a particular case, the social scientists facilitated understanding and utilization of services by the ethnic patients in the context of their belief and value systems. They acted as continuity of contact persons for the patients within the hospital system and were instrumental in providing continuity of care after discharge.

When the CMHC was funded, there was, as a result an established core of social scientists who were specialists in three of the cultures (Cuban, Haitian, and Puerto Rican) prominent in our catchment area and who, moreover, had considerable expertise in the mental health field. At the same time, the Health Ecology Project, had already established access and trust in the respective communities through long-term contact with over 100 families. The Health Ecology Project research assistants, all indigenous to the respective cultures, had accumulated a great deal of preliminary data and, inevitably, had done a considerable amount of case finding in the course of their research activities. Many of these cases were referred to the CMHS team. Moreover, extensive mapping of a large portion of the catchment area had been accomplished, which provided knowledge of housing patterns and ethnic clustering that updated the 1970 census data, transportation routes and accessibility of health facilities, alternative healing modalities used in the communities, and other types of data relevant to the use of community mental health services.

In March 1974, the Jackson Memorial Hospital-University of Miami School of Medicine Community Mental Health Program (CMHP) was funded to serve an inner-city area of 200,000 population with a median income of $4,647 and a multiplicity of social problems. The area is predominantly black (over 50 percent) and Spanish-speaking, with the balance primarily poor Anglo elderly. This descriptive statement is based on the tendency of census, hospital, and social indicator statistics to lump diverse populations under these global demographic headings. However, it is obvious both from the Health Ecology Project findings and the literature as a whole that "black" and "Spanish-speaking" are by no means adequate as identifying characteristics when it comes to sensitive mental health care. Distinct cultural differences between and among Afro-American and Afro-Caribbean groups, and among Cubans, Puerto Ricans, and other Latinos suggested the need for a model that would include staff with sufficient linguistic and cultural expertise to meet the needs of clients from diverse populations.

While this paper does not seek to ignore the fact that cultural differences among European ethnic groups (cf. Giordano 1973) and the interaction of social class and ethnicity (cf. Rosen and Frank

1964) may also impinge on mental health treatment, the model developed by the CMHP was specifically tailored to the ethnic communities and assessed needs of catchment area IV in Miami. The major characteristics of this catchment area are (1) its ubiquity of social stressors, such as poverty, unemployment, crime, poor housing, and medical problems; (2) its multilingual, ethnically diverse composition; and (3) its problems associated with ethnicity, e.g., a history of racial segregation and discrimination, large immigrant and exile populations, illegal alien status, and differential levels of acculturative stress.

The CMHP model thus began with two primary objectives: (1) to provide highly accessible, culturally appropriate services that would encompass the range of presenting complaints, and (2) to help alleviate environmental stressors by ensuring that area residents receive their fair share of adaptive resources. To this end, the program developed six teams of indigenous mental health workers for each of the major groups in the catchment area: Anglo elderly, Bahamian, Cuban, Haitian, native black American, and Puerto Rican. Each team, led by a social scientist typically at the doctorate level, provides mental health services, resource information and linkages, research expertise, consultation and education, and community development aid in the area it serves. All team members, social scientist directors, and clinical staff are matching ethnicity to the populations served. In addition to offering traditional psychotherapeutic and chemotherapeutic services, the program has a strong emphasis on environmental interventions to relieve individual reality problems and on collective efforts with other agencies for community improvement. [More comprehensive descriptions of the program may be found in the complete August 1975 issue of Psychiatric Annals and in Lefley (1974).]

One of the notable features of the program, as it developed, was the fact that approximately 60 percent of our clients have come from outreach (i.e., they have been referred by themselves or others) in the course of needs assessments and other surveys in the community. These are individuals, reflecting the parameters of "true prevalence" studies, who would not typically seek help in an orthodox mental health facility. The facilitating factor in their willingness to seek treatment derived from their being interviewed by people of matching ethnicity who spoke their own language and offered services that were accessible, culturally acceptable, and responsive to their environmental problems and their intrapsychic needs.

A second notable feature was the development of a network of "miniclinics" throughout the community, offering a culturally homogeneous social/rehabilitative milieu for precare and postcare clients. In some cases, the miniclinics have functioned as neighborhood centers, attracting a heterogeneous mix of adults, youth, and children to their social and educational activities. This mix has facilitated deinstitutionalization, since patients socialize with and are in the same role as other people seeking services. A further therapeutic component has been the involvement of patients in community development activities, giving them socially useful functions together with so-called "normal" people.

A body of information relevant to the application of culturally appropriate care has emerged in the course of treating these clients in the hospital system and the miniclinics; in ongoing supportive contacts and home visits with families; and in consultations and interventions in the schools, criminal justice system, and other community agencies. To date, this information has been shared in clinical case conferences, lectures to psychiatric and medical personnel, a few articles, and occasional lectures to interested community groups.

In terms of team organization and involvement, most of the teams began with advisory boards of community members who assisted in selecting personnel and in suggesting the range of needs in the area. The initial approach to services was one of community outreach and organization. The teams surveyed the neighborhood through block mapping and observation, reassessment of census data to determine ethnic clustering, investigation of the availability and distance of resources, and development of demographic and ethnographic profiles. Team members talked to key informants, to residents, and to people on the street; they established contact with community agencies and informal groups; and they developed linkages with the indigenous community leadership.

During the community outreach period, a number of discrete research projects were conducted at the request of a community group, e.g., the collection of supportive data to obtain external funding of day care centers and hot lunch programs for senior citizens. Inevitably, the needs assessment generated immediate case finding, necessitating mobilization of the teams as referral agents (with functions often including transportation, help with form completion, and interpretation). The first three teams staffed--Cuban, Haitian, and Puerto Rican--immediately established service offices in Community Action Agency (CAA) quarters and began dispensing social services. These high-visibility research and service activities generated a positive response from the community and laid the groundwork for acceptance of the teams as an effective mental health resource.

Community Intervention and Mobilization

In the Allapattah area of Miami, the Cuban team has established two well-functioning miniclinics, conducted numerous surveys, and become highly involved in community affairs (Sandoval 1975). Operating in an area with no other agency resources, the team has been active in attracting Community Development Project (CDP) funds into the area. With a client group as a community base and linkages established with other ethnic interest groups, team efforts have resulted in the allocation of $450,000 to this area for various social projects. Of this amount, $250,000 was earmarked for a centrally located multipurpose service center, which now includes the Cuban miniclinic as a mental health facility. This action not only brings a critically needed resource into the area but removes the discrete "mental health identity" from the miniclinic and phases into a wide range of preventive and ancillary services that are available in the same location.

The Puerto Rican team, working in Wynwood, an area with inadequate educational facilities for Spanish-speaking adults, initiated a project to bring a community school into the area. After organizing and publicizing a meeting to which 58 community leaders were invited, the team became the coordinating agent for election of an ad hoc committee and three subcommittees dealing with faculty, program curriculum, and public relations. This is the first project in which all ethnic groups in a largely Puerto Rican area came together in a collective action to benefit the community as a whole. The project, involving Puerto Ricans, Hondurans, Dominicans, Venezualans, and Peruvians, lays the groundwork for further collective activities among various Latino groups in the Wynwood area.

The Bahamian team developed a summer employment program for low-income black teenagers (14 to 16 years old) as part of Project Step. In contrast to other programs, which typically use the teenagers as cleanup and recreation assistants, the focus of the team was on training the youth in a meaningful community experience. In conjunction with another community agency, the team had developed a structured program including orientation and training in office procedures, educational films on mental health and social services, recreation, and field experience. The latter involved participation in a community survey (Needs Assessment), leaflet distribution, policing blocks, and using the agency of this group to contact and involve other youths in community activity. The goals of this project were to educate the youth to (1) become aware of and assess community needs; (2) set goals for the community and become contributing members in effecting goal-attainment; (3) learn responsibility to and for the community; and (4) receive training and certification as interviewers.

The Bahamian team has been particularly active in school consultation and education and has developed workshops for teenagers with a special focus on insight, motivation, and career development.

During the first year of operation, the Haitian team found that 70 percent of its clients were illegal aliens with multiple needs but questionable eligibility for existing federal, state, or county benefits. The team subsequently became involved in two massive advocacy projects for the Haitian community. The first, a school enrollment project, evolved from the finding that numerous Haitian children were not in school because their parents were illegal aliens and the children lacked student visas. Negotiations ensued with the school department, Catholic Services Bureau, a local Haitian organization, and Legal Services of Greater Miami. The team made contact with the Immigration and Naturalization Service (INS) and with the New York school system, which also has many Haitian students. It was found that student visas and legal status were not required in New York, and that the INS could not point to a ruling barring children from Dade County schools. Following the team's advocacy efforts, admission requirements were changed and the team itself, completing the necessary paperwork, has been successful in enrolling 750 Haitian children in school. The team handled an average of 10 school registration cases per week.

In the second project, the team conducted an advocacy program for Social Security cards for Haitian illegal aliens. Although the Social Security office had previously given cards to all applicants, a changed procedure required proof of citizenship or residency status. This ruling created a body of unemployable illegal aliens who were ineligible for welfare benefits and with no observable remedies for survival. After negotiation, the team helped over 1,200 Haitians obtain Social Security cards. Other collective efforts have involved intensive work with Haitian youth undergoing acculturative stress, particularly in raising self-esteem through ethnic heritage courses and through their involvement in helping services. The Haitian youth group participates in visiting needy people and in assisting elderly and convalescent Haitian residents. In addition to functioning as a multiethnic facility for many aftercare patients, the Haitian team has a particularly useful culture brokerage function. Called to serve as an interpreter between Creole-speaking clients and agencies such as the court system, public agencies, and the health care system, the team has been instrumental in breaking down barriers due to cultural belief systems as well as to linguistic differences.

In addition to community interventions that were directed at helping residents learn how to utilize other agencies and institutions for ameliorating specific neighborhood problems, the teams offered direct services. They provided traditional medication, psychotherapy, family and group therapy, outpatient and a range of aftercare services.

CULTURAL DIMENSIONS TO SERVICES

In developing direct services, the teams were sensitive to the multiplicity of cultural variables that may enter into the therapeutic process. There were many elements that entered into client assessment and treatment orientation.

Miami is an area of transplanted populations. Southern rural blacks face accommodation to urban living. Northern Anglo-American elderly must adjust to loss of family and income and often a life of social isolation. Immigrant groups face all the problems of uprooting and the trauma of adaptation to an alien society. A very brief overview suggests that the groups differ in type as well as level of acculturation. For example, Bahamians, representing the oldest wave of immigration, have made a substantial social and political accommodation to the black American population. Nevertheless, cultural differences persist, particularly with respect to familial pressures for achievement orientation. There may also be a generalized problem of identity diffusion. Socialized in the British system, some Bahamians consider their mores, value system, and educational background as superior to that of black Americans; others move toward assimilation; while still others opt for a Pan-Caribbean or black Nationalist identity (Bestman and Lefley 1976). The recent independence of the Bahamas has revived the question of identity in "descents" as well as immigrants. The sensitive therapist must note that Island blacks come from a different cultural mainstream than American blacks; variations in mores, values, psycholinguistic referents, and dimensions of the self-concept should be taken into account in any therapeutic interaction.

Puerto Rican acculturative stress follows a different pattern in bilingual Miami. In contrast to the extensive Cuban population, which is mainly of European extraction, Puerto Ricans are generally from lower socioeconomic origins, more racially mixed, more residentially segregated, and more rigidly cast in the traditional family-role relationships. Together with the usual effects of uprooting and transplantation, the phenomenon of minority status in a larger Spanish-speaking population tends to increase feelings of social, economic, and political inferiority. In this particular locus, the feelings of Spanish-speaking American citizens vis a vis more educated and affluent Spanish-speaking noncitizens constitutes a highly specific source of frustration and emphasizes the point that all Spanish-speaking clients can in no way be lumped together.

Cubans are the predominant ethnic co-culture in Miami and are now estimated as numbering approximately half the population of the metropolitan area. Miami Cubans are a fairly unique immigrant population. They are relatively well-educated and primarily from nonpoverty backgrounds. At first warmly accepted, the Cubans have been subjected to increasing antagonism from longer-rooted Americans, white and nonwhite, who resent the economic competition and stress on bilingual skills generated by the Cuban presence. According to our clinicians, the major psychiatric problems facing Cubans have been anxiety that is evoked by profound changes in life-style and depression that is evoked by loss of country and loss of a clearly defined sense of identity. Role identification and, in many cases, economic role reversal have been salient problems. The traditionally close-knit extended family has been subjected to numerous stressors, with women working in significantly greater numbers than before and Cuban males often forced to take jobs beneath their training or academic credentials. The generation gap is probably the most critical problem, compounded by the cultural gap between grandparents, parents, and English-speaking, Americanized children. Achievement-oriented Cuban parents are in a double bind regarding the role of schools; while education is desired, the schools act as an acculturative influence and the source of a different value system. Most families suffer from parent-child conflict regarding such issues as independence, openness to experience, and maturational activities such as dating and sexual exploration. It is not surprising that social indicators show an increase in divorce and separation rates, as well as increases in the use licit and illicit of drugs. It is also not surprising that mental health workers report rises in anxiety, paranoid ideation, and psychosomatic disorders.

It is the Haitians, however, who are probably in the greatest mental health crisis. In this case it is not acculturation per se (since most have not reached this level of cultural change) but rather linguistic, economic, political, and social barriers that constitute the greatest sources of stress. Many Haitians come to Miami as illegal aliens and from backgrounds of extreme poverty. Most have fled Haiti at great peril and have faced deportation or jail both on interim island stops and in the United States when they arrive. Thus, those who ultimately end up as psychiatric patients have undergone so many reality and survival problems and so much oppression that the typical diagnosis of "paranoid" becomes highly suspect. Further examples, given below, suggest that certain cultural belief systems also tend to make "paranoid schizophrenic" a ubiquitous but problematical diagnosis for Haitian patients.

BELIEF SYSTEMS: ALTERNATIVE HEALERS

Whites, as well as ethnic groups, utilize a wide range of therapeutic systems that are alternatives to orthodox medicine. Psychic healing, rolfing, chiropractic, and Christian Science are examples of those therapeutic systems characterized by white clients. Obeah, santería, vodun (voodoo), espiritismo and rootwork are those alternatives that are indigenous to the Bahamian, Cuban, Haitian, Puerto Rican and southern U.S. black communities, respectively. It is interesting that many health professionals view these ethnic healing systems as alternatives to orthodox medicine. In fact, it is mainstream, Western-trained therapists who are alternates to the traditional therapists or healers and their practices in a system that is a historical outgrowth of cultural beliefs and values specific to an ethnic population. So, one can conclude, that for a black American, Cuban, or Puerto Rican to seek help from a community mental health center is in reality a violation of his or her customs and traditions. Thus, the ethnic client is suspect of the kind of services there are and their ultimate worth in his or her life. Each of these ethnic healing systems is briefly described next.

Obeah, vodun, rootwork, and santería share commonalities from the Christian and West African religions, although each exhibits a unique form of its own due to growth in different environments in the New World. A characteristic of Obeah and rootwork is that there is normally no group involvement; the healers work in a one-to-one relationship with their clients. In contrast, vodun and santería adherents often gather as a group and receive additional benefits to membership such as social support and recreation.

Vodun (voodoo) is a true religion, in the same sense that Mohammedanism, Buddhism, or Christianity are all true religions; i.e., it is a set of beliefs and practices that claims to deal with the spiritual forces of the universe and attempts to keep the individual in harmonious relationship with these forces as they affect the individual's life, (Leyburn 1966, p. 134). Dahomean slaves predominated in Haiti, and their religious beliefs and practices formed the core from which contemporary vodun evolved. The greatest single influence during the years of evolutionary process was the Roman Catholic Church. The composite system that exists today in Haiti, as well as Miami, requires that its people must maintain proper relationships with the Christian God, the Catholic saints, the African Gods, and the dead. Its practitioners, called houngans (males) and mambos (females) are sought by their clients to foretell the future, cure illness and give protection from the misfortunes of life. They are also thought to have the power to cause illness or harm to another.

Obeah, prevalent in the British West Indies and the Bahamas, refers to the syncretism of the West African beliefs and practices brought to these two groups of islands by slaves and the Protestant Church's influence in these countries. Obeah men and women are thought to have magical power conferred on them by spirits to heal or bring harm. They are consulted when "things just aren't going right" or when one suffers misfortune, family difficulties, or sickness.

Although there are numerous Bahamian practitioners living and working in Miami, most refer to themselves as rootworkers or spiritual healers. Those who call themselves "Obeah men" generally live in the Bahamas and commute to Miami, serving clients in both countries.

Rootwork has been defined "as a highly organized system of beliefs shared by blacks who were raised in the southeastern United States or who retain close ties there with families and friends" (Wintrob 1972, p. 54). Its central concept is the belief that misfortune and illness can be caused as well as cured by magical means. Although it has been said that its beliefs and practices are derived from West African sources, Haitian Vodun, and European witchcraft, the influence of the Christian religion (Protestant) is also very much in evidence within the practitioners' shops in Miami. Bibles, crosses, and prayers are incorporated into most of the healing rituals.

Santería, an Afro-Cuban religious cult that draws mainly from the Cuban community in Miami, is characterized by a syncretism of African spirits (predominantly Yoruba) and Catholic saints. Many of its members call themselves Catholics, but add, "Yo soy Catolico a mi manera" (I am Catholic in my own way.). Its practitioners, termed santeros or santeras, take a completely amoral stance in their work with clients; they attempt to help or bring harm, whichever the client wishes. "Its rituals are designed to teach man how to control, how to plead, and how to make deals with the supernatural. Moral considerations are of secondary importance since the gods will be on the petitioner's side, regardless of his moral standing, as long as he makes offerings to them" (Sandoval 1975).

Although the majority of adherents in Cuba were from the lower classes and black population, santería has become popular in Miami with the upwardly mobile, middle-class Cubans (members of the lower-middle and lower strata in pre-Castro Cuba) (Sandoval 1975). One explanation for its growing popularity in Miami is that the cult has adapted to the needs of the immigrant community, many members of whom feel a sense of great loss not only of their country but of family members left behind. By means of providing a fictive extended family to all those who belong to the same cult "house" and share the same *madrina* (godmother) or *padrino* (godfather) santería has been extremely supportive to its members during the difficult days of acculturation (Sandoval 1975).

The majority of those who seek the help of a santero because of a health problem apparently suffer from psychosomatic disorders or tensions that have not yielded or do not ordinarily yield to orthodox medical treatment (Sandoval 1975). Field observations in Miami indicate that the techniques utilized in santería have been especially therapeutic in these types of cases of anxiety and psychosomatic disorders affected by acculturative stress (Sandoval 1975).

Espiritismo has been described as "a folk system of psychotherapy, . . . a means of coping with psychiatric illness and lesser distress, . . . an alternative (and often a supplement) to seeking help from professional mental health services" (Garrison 1973, p. 1). Puerto Rican clients in Miami and New York most commonly consult its healers (espiritistas) in regard to a personal or family problem, *nervios* ("nerves"), or "when the doctors say there is nothing wrong" (Garrison 1973, p. 3 and Health Ecology Project). Originating in nineteenth-century Europe, espiritismo became extremely popular among the Spanish elite that migrated to Puerto Rico. As lower-class Puerto Ricans began to adopt this belief system and fit it to their needs, they focused on the curing aspects (not emphasized within the early Spiritist movement). Traditional Puerto Rican curing techniques, folk Catholicism, and Kardecian beliefs were syncretized during this process (Koss 1973). Today, espiritismo among mainland Puerto Ricans includes the belief that our world is populated with spirits who hover around living beings and affect their daily lives in good or evil ways. The practitioners (espiritistas) are able to communicate with these spirits and intervene with them on behalf of their clients. In Miami, espiritistas generally maintain a one-to-one counseling relationship with their clients, in contrast to New York where espiritistas hold group sessions that have been described as similar to group therapy, hypnotherapy and psychodrama (Garrison 1973, p. 6). It should be emphasized that this is considered an ethical rather than a religious cult; many cult members also belong to either Roman Catholic or Pentecostal churches.

Although spiritism is most frequently associated with Puerto Ricans, it was also popular on the eastern end of Cuba in pre-Castro days and was successfully migrated to Miami with the Cuban refugees from that area.

Much consideration was given to value orientation such as individualistic versus group identity. The ethnic minorities tend to value their existence as a member of a family and cultural group, which is counter to the emphasis on individualism that predominates within the American society. Thus, in establishing plans for the individual, a great deal of attention was devoted to involving his or her various supportive systems--family, church, friends, and other relatives.

Language barriers were nonexistent because of the insistence that communication occur in the native language of the client.

The clinicians have been in collaboration with folk healers in addressing individual cases. The culturally sensitive professional may adopt various stances with respect to folk healers. Many reject their science out of hand, viewing them as charlatans, perpetrators of superstition, or workers of malevolent will. At the Center, they are considered valuable assets for learning and referral purposes.

The impact of racism on the functioning of blacks in America weighed heavily in program design. The reality of racism as a dimension in American culture was acknowledged. In the 1950s urban renewal, which is commonly referred to by Miami blacks as "nigger removal," had a devastating effect on the Overtown community to the point that the community exploded in a fit of black rage in 1984. Additionally, the first wave of Cuban refugees arrived in south Florida during the latter part of the 1950s and early part of 1960. The black community experienced displacement and high levels of unemployment. In 1980, the community experienced its second wave of Cuban refugees and a wave of Haitian boat people. A pervasive feeling of powerlessness, hopelessness, and of having lost control of one's own destiny erupted in the face of police brutality within the black community. The city was burning for several days.

The agency has taken the leadership in providing cross-cultural experiences for the inner-city communities. In response to riotous conditions, a consultation and education program specifically designed for the development of black youth has been implemented. The project is concerned with cultural and ethnic identity issues and the enhancement of self-esteem and self-worth.

UTILIZATION OF ETHNIC DATA

The primary teaching of the Center is that a knowledge or awareness of and experiencing of the client's culture is essential for effective diagnosis and therapy. It has been demonstrated that cultural beliefs and behaviors are translated into health beliefs and practices, illnesses, and/or symptoms for the clients. They are often in conflict with the cultural values and health practices and beliefs of the mental health professional who is a product of an Anglo, Western-oriented health system. Essentially, in an effort to diagnose, effect a therapeutic relationship, and establish a treatment plan, the mental health professional finds that there lacks an understanding of the etiology and definition of the "disorder," of the client's perception and expectation of the therapist's role, and of the client's thought processes and symptoms.

Traditionally among mental health professionals, effective coping with problems has been achieved through psychotherapy, whether individual or group therapy. Some of the rules of this form of treatment involve a high level of verbal communication and self-disclosure on the part of the patient; a neutral posture by the therapist; and the patient having greater insight into his or her functioning or problem, etc.

Many mental health professionals who use this approach have found that they have been essentially ineffective in providing services to individuals who are of a different cultural background. It can also be stated that those therapists having the same cultural background as the client who utilize "traditional psychotherapy" prove to be ineffective. Consequently, there is a growing awareness among mental health professionals of the importance of familiarizing ourselves with the cultural milieu of our clients in an effort to become more effective in the execution of our professional skills. This can be a complicated process because most, if not all, ethnic groups are exposed not only to their own cultures but also to the Anglo, middle-class culture and subcultures within their own ethnic group. This is evidenced, for example, in the case of the Bahamians who will have differences determined by the island (Cat Island, Eleutra, Andros, etc.) of origin and of the Puerto Ricans who have been (Wolf 1952) analyzed as having three subcultures--sugar cane workers, coffee growers, and an urban middle class.

Nevertheless, each of us has had primary exposure to a particular social context, values, goals, expectations, beliefs, and patterns of behaviors that are also shared by specific others. Thus, children of Cat Island in the Bahamas are exposed to very similar child-rearing practices, but these practices contrast with those in the island of Nassau. In Cat Island, statistics would probably reveal that nursing or other health occupations are chosen less frequently, because of the predominant belief that nursing is a "dirty" occupation. The opening of trunks after many parents' deaths has revealed hidden letters that hospitals sent to the daughters accepting them for nurse's training.

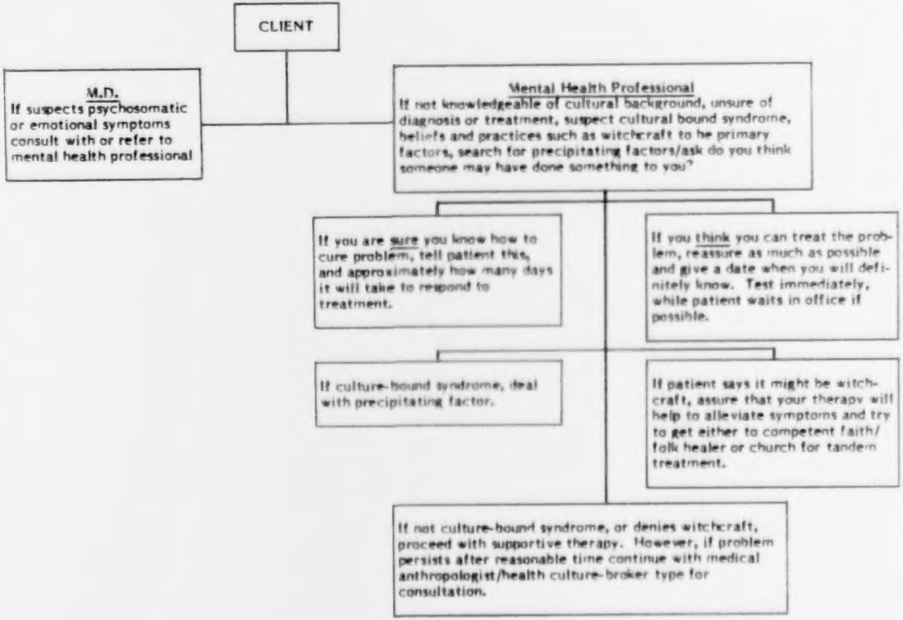
Figure 1 outlines the criteria for the use of ethnic data in clinical cases. Note that the model entails: (1) Physicians ruling out organicity in collaboration with mental health professionals. (2) Mental health professionals checking out anthropological data relevant to client's ethnicity in the diagnostic and treatment processes. (3) Mental health professionals collaborating with culturally appropriate consultants such as folk healers.

In the CMHC, symptoms and behaviors are evaluated in terms of the client's cultural background and social conditions. A diagnosis leading to a definitive statement of the mental status of an individual takes into account the criteria that his or her cultural group used for the definition of mental conditions. It has been found that the manifestations of symptoms and syndromes vary between culturally different groups, as discussed earlier.

The use of the ethnic mental health workers (cultural specialists) and ethnic data enables clients in our program to receive culturally appropriate or relevant diagnosis and therapy. The cultural specialists assist in the assessment and interpretation of presenting symptoms and test data and in the formulation of a treatment plan.

For example, in the majority of the cases of Haitian clients referred to our centers, the psychiatric diagnosis is paranoid schizophrenia. This occurred in the case of an unemployed 32-year-old female, who was married to a white American and had no children. She was hospitalized because of a suicide attempt after her husband refused to provide her with funds for a trip to Haiti. She complained of seeing and being chased by angry spirits. In telling the story of her pact with the spirits in Haiti, the mental health professionals viewed the story as extremely irrational and hallucinatory. The client demanded release from the hospital and money for a trip to Haiti. The psychiatrist, social workers, and nurses saw themselves as being confronted with several problems: (1) language, (2) lack of exposure to Haitian culture, (3) appropriate treatment of a schizophrenic who was Haitian, and (4) retention of client for treatment. Following consultation with the Haitian cultural specialists, the health professionals attending the client changed their interpretation of her

The characteristic action is to go to the M.D. first for treatment of a physical or emotional symptom. If the M.D. does not seem to know what the problem is, then patient will go to alternate healer or drop out of the healing system altogether.



CLIENT

M.D.
If suspects psychosomatic or emotional symptoms consult with or refer to mental health professional

Mental Health Professional
If not knowledgeable of cultural background, unsure of diagnosis or treatment, suspect cultural bound syndrome, beliefs and practices such as witchcraft to be primary factors, search for precipitating factors/ask do you think someone may have done something to you?

If you are sure you know how to cure problem, tell patient this, and approximately how many days it will take to respond to treatment.

If you think you can treat the problem, reassure as much as possible and give a date when you will definitely know. Test immediately, while patient waits in office if possible.

If culture-bound syndrome, deal with precipitating factor.

If patient says it might be witchcraft, assure that your therapy will help to alleviate symptoms and try to get either to competent faith/folk healer or church for tandem treatment.

If not culture-bound syndrome, or denies witchcraft, proceed with supportive therapy. However, if problem persists after reasonable time continue with medical anthropologist/health culture-broker type for consultation.

Figure 10-1. Criteria for use of ethnic data in diagnostic therapeutic processes

behavior and ceased efforts to retain her. She subsequently received treatment from a Houngan and is adhering to the conditions mandated by the spirits.

A second case example was an 11-year-old, sixth-grade black girl (Linda) of Bahamian descent who complained of "blacking out." This behavior was precipitated by the death of a 6-year-old male cousin who was very close to her, and whose spirit Linda saw frequently after his death. During the preliminary viewing of the body and at the funeral, Linda "blacked out." She continued to experience this, however, 6 months later. The school counselor referred her for evaluation and treatment after she had Linda in individual therapy for 3 months. In our servicing the case, organicity was first ruled out. We then began to explore culturally relevant factors relating to the case.

Two primary cultural beliefs were found to provide clues to Linda's behavior. A major cultural belief system relates to the importance which religion plays in black people's conceptions about health, illness, and life. Black Americans, as well as Bahamians and Haitians, believe that there are natural consequences for being disobedient, often referred to as "flying in the face of God"; one of these consequences may be an emotional problem or a retarded child. This is an outgrowth of the belief that the universe consists of natural events, which are determined by God, and unnatural events, which are the work of the devil. Of course, the devil predominates when the individual "yields to temptations" in violation of religious principles.

A second important cultural system is the function and role of the extended family. In this system, all adult family members play an active role in the rearing of the children. The family members may consist of distant relatives, close friends, neighbors, and godparents. Adults are generally respected and protected by the young, particularly the elderly, grandmothers and mothers. It is considered very unhealthy to verbalize feelings of hate toward parents, even those who are abusive or have deserted.

Thus, our treatment plan grew out of religious practices and beliefs of the immediate as well as extended family. More specifically, family therapy was the preferred mode of therapy. The sessions involved not only the parents but grandparents, aunts, and uncles. Rituals such as placing money around a bedroom door and wearing a cross to keep the spirits away were performed. These culturally appropriate treatment modalities were merged with behavior modification techniques so that the parents would refrain from reinforcing undesirable behaviors. However, if behavior modification were used alone, it would have been inadequate to deal with the family's belief system regarding etiology and effective treatment of the presenting complaint.

Some words of caution: There are inherent dangers in the wholesale adoption or application of any one explanatory system for all individuals of a particular group. Some mental health professionals in their enthusiasm for culturally appropriate treatment may conclude that all current theories of biological and psychological development and functioning are irrelevant. Others may infer that individuals sharing similar ethnicity have the same belief systems and practices. One should not ignore any of the following assumptions: (1) that human beings, regardless of culture, share a commonality of problems relating to biological and psychosocial development; (2) that within ethnic groups, individual differences may be as salient as between-group cultural differences; and (3) that within human collectives characterized as "black," "Latin," "white," "Oriental," etc., there may be significant variation in beliefs and behavior related to mental health care.

Given the assumption that there is indeed a "psychic unit of mankind," the mental health professional should not follow the avoidance behavior that in the past has relegated ethnic patients to inexperienced therapists, chemotherapy without counseling, or custodial care alone. While there is concurrence with the belief that most individuals who differ in sociocultural background from middle-class caregivers may not respond positively to orthodox psychotherapeutic procedures, a number of options are available to the sensitive therapist for ensuring optimal benefits. The following suggestions comprise a preliminary methodology that may be generalized across cases:

Literature Review

Before initiating treatment, the caregiver should familiarize himself or herself with the available literature on the client's culture. This should include not only sociological and anthropological literature but the available studies of cultural profile differences on standard psychological/psychiatric instruments. While this may seem a big order, it should be noted that (1) this type of familiarization should be built into any type of academic training and (2) the results may serve as a body of core knowledge for subsequent clients from this type of generic group.

Ethnic Consultants

There should be initial and ongoing consultation and review with ethnic consultants. In this connection, two points should be stressed: (1) The consultant need not be a professional; it is far more important that the consultant derive from and understand the client's specific ethnic and sociocultural experiences. (2) It would be wise for professionals of matching ethnicity to also have these types of consultants, mitigating the effects of resocialization in the orthodox system and the social distance created by educational and class differences. In this type of interaction, the caregiver should, in addition to requesting input on social and cultural context, check out and validate interpretation of symptoms and behaviors and seek clues for alternative interpretation.

Cultural Exposure Experience

Although it is unlikely that most therapists will avail themselves of this option, it would be wise for a caregiver to have some exposure, no matter how brief, to the life-style of the ethnic client. This may involve cruising through an ethnic neighborhood, attending a church service, shopping in a ghetto supermarket, or simply observing interactions in groups of people from different cultures in a clinic waiting room.

Utilization Patterns

Cultural material should be taken into account in interpreting the client's utilization of services; e.g., times of day when "no shows" are most apparent; appointment-keeping patterns (often interpreted as "resistance" when time-orientation values are mismatched); and the relationship of utilization to appointment-spacing.

Involvement of Significant Others

In contrast to white, middle-class clients whose families have some familiarity with the exclusion ethos of psychoanalytically oriented individual therapy, Spanish-speaking families generally expect to be included in the therapeutic transaction. Here, several items should be noted: (1) the mode of involvement must be culturally appropriate, e.g., in a lower-class Puerto Rican or Chicano family the caregiver cannot ask a wife to bring her husband in for counseling; this should be done through a respected third-party family member (cf. Lombillo and Geraghty 1973); (2) the range of family members must be culturally appropriate. The nuclear parents-siblings arrangement of conventional family therapy is inadequate for the black and Spanish-speaking extended families, where aunts, uncles, and grandparents may play a significant role in family dynamics and child rearing.

Belief Systems

The therapist must be sensitive to alternative conceptions of causation and remediation of illness--particularly to the types of supernatural belief systems discussed earlier. Here, however, a caveat should be noted as to superimposing newly acquired knowledge on what may be standard types of neurotic or psychotic symptomatology. That is, all patients who verbalize persecution from others and also happen to be black Haitian are not necessarily rooted; they may simply be expressing paranoid ideation in culturally defined ways. The use of ethnic consultants is particularly important in these types of situations.

Adaptive Behavior

Is the therapeutic goal adaptive in the social and cultural milieu to which the client returns? Will the behaviors that are being shaped enable the client to function at a higher level of social adaptation, or do they have the potential for exacerbating the client's problems in the society in which he or she must live? Are they congruent with the client's belief and value system? Again, these issues should be subjected to ethnic consultation and peer review because the prescribed treatment plan would be ineffectual if it led to conflict with cultural norms.

Interpretation of Behavior

The well-trained therapist interprets both verbal and nonverbal behavior in terms of intrapsychic functioning. The culturally sensitive therapist adds another dimension to observations of behavioral cues. Signs of discomfort or unease must be assessed in terms of communicative difficulties or threats against cultural norms, as well as threats to ego-functioning. Since the caregiver is an authority figure, the client may be unable to verbalize anxieties that ensue from conflicting norms, rather than from substantive aspects of the interaction. The pitfalls of erroneous interpretation are particularly salient in these cases. In the example previously alluded to (i.e., a caregiver asking a Spanish-speaking wife to bring her husband in the marital counseling), the wife's behavioral discomfort may indicate fear of transgressing a cultural norm, but may be misinterpreted as adverse feelings toward the husband or fear of self-disclosure.

Using a Checklist

As a overall methodology, it is suggested that the sensitive therapist use cultural material as a backdrop of knowledge against which to "check off" items that may or may not be relevant to the therapeutic process. The "indexing and loop" model of the digital computer is probably the best approximation of this process. Input should be checked off against known indices of cultural differences; if the datum seems to fit, it should be used. If the datum is contradictory, it should definitely be assessed for resistance and cultural deviance, but alternative explanations should be sought for and applied. If the datum is irrelevant, it should be dropped.

In all cases, it should be reemphasized that ethnic consultants should be used to aid in analyzing and interpreting the "data" of the therapeutic process. Ethnic consultants provide the additional information that ultimately expands the clinician's options for interpretation of symptoms and behaviors and the selection of appropriate treatment alternatives.

CROSS-CULTURAL TRAINING PROJECTS

Several approaches have been indicated in the provision of cross-cultural training. Gudykunst et al. (1977) have emphasized the need for an integrated approach to cross-cultural training, citing six different approaches: intellectual (cognitive); area simulation (environment similar to the host culture); culture awareness (provision of culture-general information); a behavioral approach, focusing on behaviors specifically adaptive in the host culture; an interaction approach, which involves intercultural communication and exploration of one's own cultural value orientations in multicultural participant groups; and, interrelatedly, personal self-awareness, based on the assumption that the trainee's self-understanding will lead to a greater ability to adjust in another culture.

The University of Miami's Cross-Cultural Training Institute for Mental Health Professionals (CCTI), which is funded by a National Institute of Mental Health (NIMH) Training Grant, was developed to provide highly intensive 8-day continuing education workshops to mental health practitioners currently working in agencies serving low-income, culturally diverse populations. The three major objectives were to (1) provide practitioners with a transcultural perspective and practical skills in serving culturally contrasting clients, (2) teach techniques for outreach and involvement in different ethnic communities, and (3) maximize the conditions for impact of training in the home agency in terms of spinoff effects and institutional change. The aim was also to enable minority professionals to learn about ethnic groups other than their own and to provide additional support for institutional change in their home communities.

Training staff were primarily black and Hispanic faculty members from the CMHC and Department of Psychiatry but included other academicians, practitioners, folk healers, community aides, and various consultants. The curriculum involved a synthesis of didactic, transactional, experiential, and cultural immersion techniques, as well as operationalized action plans for transfer of training. Lecture materials focused on present-day culture in historical perspective, such as Afrocentric cognitive systems, religion, world view and value systems, family structure and interactions, age and sex roles, supernatural beliefs and alternative healing modalities, and interracial intercultural communication. Normative behavior, life-styles, support systems, cultural stressors and coping mechanisms, adaptive strategies for survival, and the interrelationships of ethnic minority status and mental health were explored. Presentations were given on community involvement in needs assessment and planning service delivery. Practicum experiences included videotaped role playing and simulation of therapeutic encounters with clients and families of other cultures. This involved a behavioral measure in which trainees were videotaped in interaction with a role-playing minority "client" (a black social worker) before and after training. The interview was prestructured and focused on an empirically derived representative case: A mother with two small children whose husband has deserted her, with no visible means of support, has been referred by the local welfare agency to the mental health center. Apparently the woman has manifested some emotional problems, but she has little idea of why she was referred and keeps emphasizing the need to resolve her reality problems. The interview was built around a standardized format of six statements made by the person role playing the client. Particularly important was cultural immersion, which was utilized throughout the 8 days and involved systematic participant observation in ethnic neighborhoods; visits to restaurants, bars, and botanicas; street encounters; church participation; attendance at ethnic community clinics; and even visits to clients' homes, with group processing of reactions.

In response to the Cuban and Haitian influx of 1980, NIMH provided funds to the Department of Psychiatry of the University of Miami for the development of a mental health human services center for the training of paraprofessionals in cultural approaches for services to ethnic minorities. Specific emphasis was placed on Cuban and Haitian culture. The author was principal investigator. Human services providers from across the State of Florida received training in cultural practices, beliefs and values, and cultural approaches to provision of care for Cuban and Haitian refugees.

The Mental Health Human Service Training Center (MHHSTC) staff developed and refined several teaching/training techniques. The following were the materials/teaching/training methods and resources used in the project:

1. Modules. Two sets of 20 modules were prepared by the MHHSTC trainers and consultants in which the same areas of culture were developed for the Cuban and the Haitian refugee groups. This information was creatively used with other training techniques/resources in order to provide concise and updated information to the trainees.

2. Library. In addition to having access to the University of Miami Library, the MHHSTC built its own library with literature pertinent to the refugees' populations and cultures, training and teaching strategies and methodologies, cross-cultural studies of different ethnic groups, transcultural psychiatry literature, folk-healing systems in cultural and psychological perspectives, etc. The library resources also included journals, articles, and daily newspaper clippings with local information about the refugee groups.

3. Videotapes. The MHHSTC trainers made extensive use of the audiovisual equipment for the preparation and/or presentation of materials about the refugees. Key individuals that work with Cuban and Haitian entrants were interviewed and recorded on tapes, which later on were shown during training sessions. For example, key individuals from the Refugee Assistance Program, the Catholic Service Bureau, and the Christian Community Service Agency (CCSA) were videotaped during interviews conducted by the trainers concerning the services provided by these respective agencies. These interviews were shown when the topic of Inter-Agency Linkages was presented to the trainees. In proved very useful for the Public Health Nurses and Vocational and Rehabilitation Counselors working with Cuban and Haitian entrants. Also, the Center made extensive use of three documentary videotapes dealing respectively with each cultural group: (Cuban) "Against Wide and Tide: A Cuban Odyssey"; (Haitian) "The Unwanted Refugees"; and (Cuban) "In Their Words." The technique of videotaping was also very helpful. It gave trainees a chance to see themselves (e.g., during role playing) and

get criticisms from other trainees and the trainers concerning their styles of interaction and performance (e.g., interviewing skills, self-presentation, self-reports). Also it was instrumental in skill-building techniques to deal with cultural differences in body language, typical mannerisms, and culturally appropriate modes of expression.

Guest Speakers and Consultants: The MHHSTC had provision for the use of guest speakers and/or consultants whenever necessary. Consultants provided the trainers with the training skill and skill-building and/or specialized information regarding cultural aspects of both refugees' groups.

Lecturettes: Brief presentations about Haitian and/or Cuban cultures were made with the purpose of providing diversified information to the trainees and also to provoke open discussions on their part.

Handouts: Literature (articles), tables, maps, bibliographies, and outlines were distributed to the trainees as supplementary information that would enhance their understanding of and expand on the topics being presented in the training.

Visual Aids: The use of transparencies in the overhead projector and the newsprint pad and easel proved to be very effective training tools. The transparencies helped the trainees follow the outline of the lecturettes, while the large-print papers were posted around the room so that materials, items, or issues could be followed visually (not erased) and avoid repetition or overlap of issues, data, etc.

Role Playing: This technique was fruitful in sensitizing the trainees both to their particular job roles as well as the position of the refugee in relation to the mental health/human services worker. It allowed for an empathy of feelings and attitudes achieved when one is "forced" to step in another person's shoes. This exercise was productive and conducive to insight with the Public Health nurses when they were asked to role play a typical encounter with a Cuban and a Haitian patient. Elements of body posture and language, manner of speech, eye-contact and many other culturally significant behaviors became obvious when the group observed and criticized the interview situation.

Small-Group Discussion and Sharing: The technique of dividing into small groups (preferably five to six trainees per group) and assigning each a particular question or set of issues to be discussed was useful in getting the trainees to hear others discuss and exchange opinions. This would be difficult if it were to be done in larger groups. Each small group selected a spokesperson to write the opinions, ideas, or solutions proposed by the group's members and to the group at large the conclusions.

Cultural Immersion: A "cultural learning experience" was accomplished through direct immersion of the trainees in the refugee's area. The idea of "participant-observation" is at the basis of the cultural immersion experience. Trainees were taken to restaurants, botanicas, churches, and in the streets of the areas in Miami known as "Little Haiti" and "Little Havana," where they established direct contacts with the refugees. A participant-observer role created the possibilities for the trainee to feel empathy and understanding for the refugee's group. A "social scientist" attitude is at the core of this technique (i.e., viewing behavior and comparing it with that of other ethnic groups and one's own, analyzing structures, and checking for differences and similarities with one's own culture patterns). After the immersion, each trainee had a chance to share with the group what he or she saw and experienced in the community.

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